

24  
No. 89-1048-CFX  
Status: GRANTED

Title: FMC Corporation, Petitioner  
v.  
Cynthia Ann Holliday

Docketed:  
December 29, 1989

Court: United States Court of Appeals  
for the Third Circuit

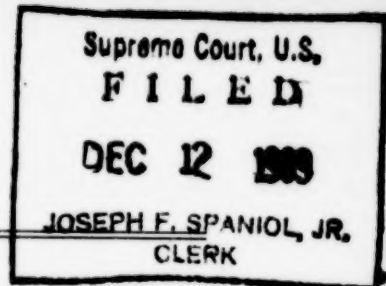
Counsel for petitioner: Turner, Harry Woodruff

Counsel for respondent: Johnson, Thomas G.

Entry	Date	Note	Proceedings and Orders
1	Dec 29 1989	G	Petition for writ of certiorari filed.
2	Jan 26 1990		Brief amicus curiae of Chamber of Commerce of the United States of America filed.
3	Jan 26 1990		Brief amicus curiae of Self-Insurance Institute of America, Inc. filed.
4	Jan 26 1990		Brief amici curiae of Teamsters Health and Welfare Fund of Philadelphia, et al. filed.
5	Jan 31 1990		DISTRIBUTED. February 16, 1990
7	Feb 1 1990	X	Brief amicus curiae of Pennsylvania Trial Lawyers Association filed.
8	Feb 1 1990	X	Brief amicus curiae of Central States, SE and SW Areas Health and Welfare Fund filed.
6	Feb 2 1990		Brief of respondent Cynthia Ann Holliday in opposition filed.
9	Feb 9 1990	F	Response requested -- JPS.
10	Feb 20 1990		Petition GRANTED. *****
12	Mar 19 1990		Order extending time to file brief of petitioner on the merits until April 20, 1990.
14	Apr 19 1990		Brief amicus curiae of Self-Insurance Institute of America, Inc. filed.
15	Apr 19 1990		Brief amicus curiae of Travelers Insurance Company filed.
13	Apr 20 1990		Brief amicus curiae of National Coordinating Committee for Multiemployer Plans filed.
16	Apr 20 1990		Brief amicus curiae of Chamber of Commerce of the United States of America filed.
17	Apr 20 1990		Brief amicus curiae of United States filed.
18	Apr 20 1990		Brief amicus curiae of Central States, SE and SW Areas Health and Welfare Fund filed.
19	Apr 20 1990		Joint appendix filed.
20	Apr 20 1990		Brief of petitioner FMC Corp. filed.
21	Apr 20 1990		Brief amici curiae of Teamsters Health and Welfare Fund, et al. filed.
23	May 4 1990	G	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
22	May 7 1990		Order extending time to file brief of respondent on the merits until June 15, 1990.
24	May 9 1990		Brief amicus curiae of American Optometric Association filed.
25	May 21 1990		Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided

Entry	Date	Note	Proceedings and Orders
			argument GRANTED.
26	Jun 5 1990	Brief amicus curiae of American Podiatric of Medical Assn. filed.	
27	Jun 14 1990	Brief amicus curiae of American Chiropractic Assn. filed.	
28	Jun 14 1990	Brief amicus curiae of Pennsylvania Trial Lawyers Association filed.	
29	Jun 15 1990	Brief of respondent Cynthia Holliday filed.	
30	Jun 15 1990	Brief amici curiae of National Conference of State Legislatures, et al. filed.	
31	Jul 2 1990	CIRCULATED.	
32	Jul 18 1990	X Reply brief of petitioner FMC Corp. filed.	
33	Jul 23 1990	SET FOR ARGUMENT TUESDAY, OCTOBER 2, 1990. (3RD CASE)	
34	Aug 31 1990	Record filed.	
		* Certified copy of original record received.	
35	Sep 13 1990	Record filed.	
		* Certified copy of C. A. Proceedings received.	
36	Oct 2 1990	ARGUED.	





No. \_\_\_\_\_

In The  
**Supreme Court of the United States**  
 October Term, 1989

—◆—  
 FMC CORPORATION,

*Petitioner,*

v.

CYNTHIA ANN HOLLIDAY,

*Respondent.*

—◆—  
**PETITION FOR A WRIT OF CERTIORARI TO THE  
 UNITED STATES COURT OF APPEALS FOR THE  
 THIRD CIRCUIT**  
 —◆—

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December 29, 1989

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**QUESTION PRESENTED**

Whether ERISA's express preemption provisions, as interpreted in *Metropolitan Life v. Massachusetts*, prohibit states from applying state insurance regulations to self-funded employee welfare benefit plans, as to which the courts of appeals are in conflict?

## PARTIES TO THE PROCEEDINGS

Petitioner, FMC Corporation, is a Delaware corporation with its principal place of business in Illinois. FMC's subsidiaries include: FMC do Brasil S.A., FMC Mid-Atlantic Investments Limited, Mid-Atlantic Acceptance Company Limited, FMC Gold Company, FMC Paradise Peak Corporation, FMC Jerritt Canyon Corporation, FMC International, A.G., FMC Wyoming Corporation, Foret, S.A., Lithium Corporation of America. Respondent, Cynthia Ann Holliday, is an individual and citizen of Pennsylvania.

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- C. Opinion of the United States District Court for the Western District of Pennsylvania.....C1
- D. Opinion of the United States District Court for the Northern District of California in *FMC Corp. v. The Good Samaritan Hospital*.....D1

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# PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

The Petitioner, FMC Corporation ("FMC"), respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Third Circuit, entered in the above-entitled proceeding on September 11, 1989.

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## OPINIONS BELOW

The district court's opinion (C1) is not officially reported. The opinion of the United States Court of Appeals for the Third Circuit is reported at 885 F.2d 79 (3d Cir. 1989). (A1)

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## JURISDICTION

The Court of Appeals entered its opinion and judgment in this case on September 11, 1989. (A1) FMC's Motion for Rehearing *En Banc*, filed on September 21, 1989, was denied by the Court of Appeals on October 5, 1989. (B1)

The jurisdiction of this Court to review the decision of the Court of Appeals is invoked under 28 U.S.C. §1254(1).

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## STATUTES INVOLVED

Section 514(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), provides:



Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

29 U.S.C. §1144(a).

Section 514(b)(2)(A) of ERISA provides:

Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. §1144(b)(2)(A).

Section 514(b)(2)(B) of ERISA provides:

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. §1144(b)(2)(B).

Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 (the "Motor Vehicle Law") provides:

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under section 1719 (relating to coordination of benefits).

75 Pa. Cons. Stat. Ann. §1720 (Purdon 1984).

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### STATEMENT OF THE CASE

FMC, like many other employers, operates a self-funded employee benefit plan, the FMC Salaried Health Care Plan (the "Health Plan").<sup>1</sup> (C1)<sup>2</sup> The Health Plan

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<sup>1</sup> Self-funded plans cover a vast number of American workers. More than 9½ million Americans are covered by health funds that are self-funded. "Employee Benefits in Medium and Large Firms, 1988", U.S. Department of Labor, Bureau of Labor Statistics, Bulletin 2336 (August 1988). Moreover, a 1986 study by the Health Care Financing Administration (a division of the U.S. Department of Health and Human Services) revealed that four out of every five companies and unions, with 5,000 or more plan participants, operated self-funded health care plans. P. McDonnell, A. Guttenberg, L. Greenberg, R.H. Arnett III, "Self-Insured Health Plans," *HCFA Review*, Vol. 8 No. 2 (1986). The HCFA study also found that more than 50 percent of all employees with health insurance participate in self-funded plans.

<sup>2</sup> The district court disposed of this case on cross-motions for summary judgment, finding that there were no disputed

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covers medical expenses incurred by FMC employees and their covered dependents. All funds used by the Health Plan to provide medical benefits to the participants come directly from FMC; FMC does not purchase insurance to provide these benefits. (C1)

The fiscal integrity of the Health Plan is maintained through, among other ways, the exercise of subrogation rights. The Health Plan provides:

The FMC self-insured benefit program is automatically assigned the right of action against third parties in any situation in which benefits are paid to employees or their dependents. If you bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled you must reimburse the Plan for the benefits provided.

(C2)

Cynthia Ann Holliday ("Holliday") is the daughter of Gerald Holliday, an FMC employee. Mr. Holliday subscribed to FMC's Health Plan, and his daughter was a covered dependent. (C1) The Health Plan paid a substantial portion of the approximately \$178,000 in medical expenses incurred by Ms. Holliday in connection with injuries she suffered in an automobile accident. (C1)

FMC learned that the Hollidays filed a tort action in Pennsylvania state court (the "Pennsylvania Action")

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material facts. The facts referred to in this section were those relied upon by the district court in its opinion.

against the negligent driver<sup>3</sup> and notified the Hollidays that it intended to exercise its subrogation rights with respect to any recovery. (C2) The Hollidays rejected FMC's claim, contending that Section 1720 of the Motor Vehicle Law prohibits such subrogation.<sup>4</sup> (C3) Thereupon, FMC sought a declaratory judgment from the district court.<sup>5</sup>

Both FMC and Ms. Holliday moved for summary judgment. The district court (Bloch, J.) found that there were no disputed material facts, granted Ms. Holliday's

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<sup>3</sup> On May 2, 1989, the state court in the Pennsylvania Action approved a settlement agreement whereby \$49,875.50 plus accrued interest was placed in an escrow account in the name of Ms. Holliday.

<sup>4</sup> Section 1720 provides:

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under section 1719 (relating to coordination of benefits).

<sup>5</sup> 75 Pa. Cons. Stat. Ann. §1720 (Purdon in 1984). Both the district court and the Court of Appeals held, before reaching the preemption question presented to this Court, that by its terms Section 1720 applies to self-funded plans, such as the Health Plan.

<sup>5</sup> The jurisdiction of the district court was invoked under 28 U.S.C. §1332 because of diversity of citizenship, FMC being a citizen of Delaware, with its principal place of business in Illinois, and Holliday being a citizen of Pennsylvania.

motion and denied FMC's motion. *FMC Corp. v. Holliday*, No. 88-1098 (W.D. Pa. March 14, 1989). (C1)

The Court of Appeals affirmed the district court's decision, holding: (1) that Section 1720 of the Motor Vehicle Law applies to self-funded plans and thus precludes FMC from exercising its contractual subrogation rights, *FMC*, 885 F.2d at 83; and (2) that Section 514 of ERISA does not preempt Section 1720 of the Motor Vehicle Law from application to FMC's self-funded Health Plan since Section 1720 does not conflict with a core type of ERISA matter. *Id.* at 83-90. The Court of Appeals' holding on the preemption question brings FMC to this Court.

#### REASONS FOR GRANTING THE WRIT

##### 1. A Substantial and Direct Conflict Among the Courts of Appeals Exists and Will Be Resolved By a Decision in This Case.

In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), this Court held that ERISA preempts the application of state insurance laws to uninsured, or self-funded, employee welfare benefit plans. *Id.* at 741, 747. In so doing, this Court gave life to the distinction between insured and self-funded plans which Congress created in the so-called "deemer clause" of ERISA's preemption statute, Section 514(b)(2)(B). However, a conflict over whether ERISA preempts all state insurance laws as applied to self-funded plans now exists among the circuits.

Since *Metropolitan Life*, seven Courts of Appeals have considered whether Congress intended to preempt all state insurance laws as applied to self-funded benefit plans. Five Courts, the Fourth, Fifth, Seventh, Eighth and Ninth, have followed *Metropolitan Life*, holding that Section 514 of ERISA prohibits states from regulating self-funded benefit plans.<sup>6</sup> However, two Courts, including the Court of Appeals in this case, have ignored Congress and the plain language of the statute, have summarily dismissed the relevant holding in *Metropolitan Life* as *dictum*, and have created two different tests to determine the scope of the "deemer clause."<sup>7</sup> This direct conflict

<sup>6</sup> See *Baxter v. Lynn*, 886 F.2d 182, 186, *reh'g denied*, \_\_\_ F.2d \_\_\_ (8th Cir. 1989) (noting that even if state subrogation law had been saved from preemption as a law that regulated insurance, the "deemer clause" of Section 514 clearly prevents application of the subrogation law to a self-funded benefit plan); *Reilly v. Blue Cross and Blue Shield United of Wisconsin*, 846 F.2d 416, 425-26 (7th Cir.), *cert. denied*, 104 S. Ct. 145 (1988) (holding that, regardless whether plaintiff's state law claims fall within insurance savings clause, Section 514 of ERISA preempts those claims when made against self-funded benefit plan); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1161-62 (9th Cir. 1986) (holding that Section 514 of ERISA prevents application of Arizona anti-subrogation law to self-funded benefit plan); *Powell v. Chesapeake & Potomac Telephone*, 780 F.2d 419, 423 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (holding that Section 514 of ERISA prevents application of Virginia insurance trade practice laws to self-funded benefit plan); *Children's Hospital v. Whitcomb*, 778 F.2d 239, 242 (5th Cir. 1985) (holding that Section 514 of ERISA prevents application of a Louisiana mandatory benefits law to a self-funded benefits plan).

<sup>7</sup> *FMC Corp. v. Holliday*, 885 F.2d 79, 89-90, *reh'g denied*, \_\_\_ F.2d \_\_\_ (3d Cir. 1989) (holding that Pennsylvania

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calls for this Court to exercise its jurisdiction to define clearly the breadth of ERISA's preemption provisions. A decision in this case will eliminate confusion and clarify the multiple and conflicting obligations now imposed on self-funded plans by the current disarray in the circuits.<sup>8</sup>

This Court in *Metropolitan Life* employed a three-part analysis following the structure of Section 514 in considering whether state regulation of self-funded benefit

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anti-subrogation law as applied to self-insured benefit plan was not preempted by Section 514 of ERISA because the Pennsylvania law did not "intentionally or unintentionally address[] a core type of ERISA matter which Congress sought to protect by the preemption provision"); *Northern Group Services v. Auto Owners Insurance Co.*, 833 F.2d 85, 89-93 (6th Cir. 1987), *cert. denied*, 108 S. Ct. 1754 (1988) (holding that Michigan coordination of benefits law as applied to self-funded benefit plan was not preempted by ERISA because in that case there was no ERISA interest in uniformity which outweighed the interest in state regulation of insurance).

There is also a Third Circuit decision in accord with the majority of circuits and *Metropolitan Life*. See *Insurance Board of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 410-13 (3d Cir. 1987) (holding that Pennsylvania's mandated benefits law could not be applied to a self-funded benefit plan because it was preempted by ERISA).

<sup>8</sup> The imposition of conflicting obligations is not merely hypothetical. Indeed, FMC's Health Plan itself has been subjected to conflicting decisions on the specific issue of whether the "deemer clause" prevents application of state anti-subrogation laws to its self-funded plan. Compare *FMC v. Holliday*, 885 F.2d 79 (3d Cir. 1989) with *FMC Corp. v. Good Samaritan Hospital of the Santa Clara Valley*, (No. C-88-3092 - FMS) (N.D. Cal. December 5, 1988). (D1)

plans is preempted by ERISA.<sup>9</sup> It is at the critical third step, the analysis of the "deemer" clause, where the conflict among the circuits lies.

First, Section 514(a), ERISA's broad preemption provision, provides that ERISA shall preempt "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." §514(a), 29 U.S.C. §1144(a). "The phrase 'relate to' was given its broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.'" *Metropolitan Life*, 471 U.S. at 739, quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983).

Second, Section 514(b)(2)(A), the so-called "insurance savings" clause, provides that ERISA does not preempt any state law "which regulates insurance, banking or securities." 29 U.S.C. §1144(b)(2)(A). A state law "regulates insurance" if it meets the common-sense requirement that it is specifically directed toward some aspect of the insurance industry, see *FMC*, 885 F.2d at 86, citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, \_\_\_ (1987), or if it falls within the reference in the McCarran-Ferguson Act,

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<sup>9</sup> The Court of Appeals below belittled this Court's analysis as "stating the obvious more than providing guidelines for surmounting [the] difficulties" in interpreting ERISA's preemption provisions. *FMC*, 885 F.2d at 84.

15 U.S.C. §1011 *et seq.*, to the "business of insurance." *Metropolitan Life*, 471 U.S. at 742-43.<sup>10</sup>

Section 514(b)(2)(B), ERISA's "deemer clause," limits the reach of the insurance savings clause, providing:

Neither an employee benefit plan nor any trust established under such a plan, shall be deemed to be an insurance company . . . for the purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts.

29 U.S.C. §1144(b)(2)(B).

Thus, the "deemer clause," as interpreted in *Metropolitan Life* and by the Fourth, Fifth, Seventh, Eighth and Ninth Circuits, along with the Third Circuit in *Muir*, prohibits the application of any state insurance law to a self-funded employee benefit plan.<sup>11</sup> These cases applied this bright-line test: if a state purports to apply its insurance law to a self-funded plan, it is preempted by virtue of the "deemer clause."

<sup>10</sup> The three factors relevant to whether a practice falls within the "business of insurance" are "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Metropolitan Life*, 471 U.S. at 743, quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (emphasis in original).

<sup>11</sup> See *Baxter*, 886 F.2d at 186; *Reilly*, 846 F.2d at 425-26; *Muir*, 819 F.2d at 410-13; *Pacyga*, 801 F.2d at 1161-62; *Powell*, 780 F.2d at 423; *Whitcomb*, 778 F.2d at 242.

The Court of Appeals below and the Sixth Circuit in *Northern Group Services* turn their backs on this bright line test, essentially rewriting Section 514(b)(2)(B) of ERISA, and creating two different, but equally amorphous, tests for determining when ERISA preempts state insurance laws. These two decisions not only contravene precedent and the clear language of the statute; they also make constant litigation over the scope of the "deemer clause" inevitable.<sup>12</sup>

The test created by the Court of Appeals below to govern the scope of the "deemer clause" is as follows:

[T]he proper inquiry under the deemer clause is whether the state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the preemption provision. The court, reviewing a state insurance law, should inquire whether the law conflicts with any substantive mandate in ERISA.

*FMC*, 885 F.2d at 89-90. The Court of Appeals acknowledged that the "deemer clause" and *Metropolitan Life* require courts to observe the distinction between insured and self-insured plans, but asserted that under *FMC* "insured plans would *per se* survive the deemer clause, while self-insured plans would merely be considered on a

<sup>12</sup> Indeed, such confusion is clearly evident in a recent Sixth Circuit decision in which the panel purports to follow *Northern Group Services* but holds that the same Michigan insurance law which was held not to be preempted by the *Northern Group Services* panel is, in fact, preempted by ERISA – but only because of an "added gloss" given to the interpretation of the Michigan statute. *Liberty Mutual Insurance Group v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384, 1387-88, *reh'g denied*, \_\_\_ F.2d \_\_\_ (6th Cir. 1989).



case-by-case basis as to whether the state regulation involved affects a central concern of ERISA." *FMC*, 885 F.2d at 89.

On the other hand, the Sixth Circuit in *Northern Group Services* employed a "presumption" against preemption and a selective analysis of "[c]ertain aspects of the legislative history" to fashion the following test:

[I]n the absence of a showing of state purpose specifically to regulate the content of welfare benefits provided by ERISA, the effect of the deemer clause should be assessed by a balancing of the interests in federal uniformity against those of state primacy in the regulation of insurance.

*Northern Group Services*, 833 F.2d at 92-93. Both *FMC* and *Northern Group Services* require a case-by-case preemption inquiry, in stark contrast with the bright-line analysis of *Metropolitan Life* and its progeny. Moreover, the Sixth Circuit's test differs significantly from the test created by the Third Circuit in that the former employs a balancing test, weighing the federal interest in uniformity with state interest in regulating insurance, while the Third Circuit test will have district courts engaging, without direction, in defining "core" ERISA concerns. Only state laws conflicting with such concerns will be preempted. Not only do the tests set forth by the Sixth Circuit and the Third Circuit differ from each other, but they also differ from the majority of circuits and *Metropolitan Life*.<sup>13</sup>

<sup>13</sup> In contrast to this Court in *Metropolitan Life* and the majority of circuits, the courts in *FMC* and *Northern Group*

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Thus, a substantial conflict exists among the Courts of Appeals on the question whether Section 514 of ERISA absolutely preempts state insurance law as applied to self-funded benefit plans. Six of the eight Courts of Appeals considering the issue have protected self-funded benefit plans from potentially conflicting and inconsistent state regulations.<sup>14</sup> The other two panels have rewritten ERISA's preemption section (see note 13, *supra*), have set forth different tests by which district courts are to decide the preemption issue and have opened the door for state encroachment on this area of exclusive federal regulation.<sup>15</sup> The

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*Services* presume that self-insured plans are, in fact, "in the business of insurance" and are thus subject to state insurance regulation. This premise flies in the face of the plain language of ERISA's deemer clause which flatly states that an employee benefit plan is not to be deemed to be engaged in the business of insurance for purposes of any state laws purporting to regulate insurance. See *Kilmer v. Central Counties Bank*, 623 F.Supp. 994, 1001 (attempt to treat self-insured plan as if it were an insurance company flies in the face of the deemer clause). The Court of Appeals makes this unsupported presumption, it candidly states, so that the three ERISA preemption provisions will "make sense." (A23)

<sup>14</sup> *Baxter v. Lynn*, 886 F.2d 182, *reh'g denied*, \_\_\_ F.2d \_\_\_ (8th Cir. 1989); *Reilly v. Blue Cross and Blue Shield United of Wisconsin*, 846 F.2d 416 (7th Cir.), *cert. denied*, 104 S.Ct. 145 (1988); *Insurance Board of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986); *Powell v. Chesapeake & Potomac Telephone*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986); *Children's Hospital v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985).

<sup>15</sup> *FMC Corp. v. Holliday*, 885 F.2d 79, *reh'g denied*, \_\_\_ F.2d \_\_\_ (3d Cir. 1989); *Northern Group Services v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 108 S.Ct. 1754 (1988).

existence of three separate tests by which district courts and plan administrators are to determine whether a state insurance law is preempted by ERISA squarely presents this Court with the opportunity to resolve a substantial and ripe conflict among the circuits and to prevent much unnecessary litigation.

## 2. The Third Circuit's Decision Below Is Erroneous and Conflicts With This Court's Decision in *Metropolitan Life*

The Court of Appeals below flatly rejected this Court's decision in *Metropolitan Life* and criticized the opinion because "the Court cited neither statutory text nor legislative history" in arriving at its distinction between insured and self-funded plans, but instead relied "on vague language in Congress' *post hoc* study." *FMC*, 885 F.2d at 89. The court below ultimately concluded that reliance upon the distinction between insured and self-funded plans set forth in *Metropolitan Life* was "not proper in the face of [the] direct consideration of congressional intent" undertaken in both *FMC* and *Northern Group Services*. *FMC*, 885 F.2d at 89. The Court of Appeals' cavalier treatment of *Metropolitan Life* reveals that it either ignored or misunderstood that decision.

In *Metropolitan Life*, this Court decided that ERISA did not preempt a Massachusetts statute which, as applied to plans that purchased insurance, required that certain minimum mental-health-care benefits be provided to Massachusetts residents covered by an insured employee health-care plan. *Metropolitan Life*, 471 U.S. at

738-47.<sup>16</sup> However, to decide whether the mandated-benefits statute at issue was among those insurance laws which Congress intended to protect from preemption with the "insurance savings clause," this Court first analyzed the structure of Section 514 of ERISA, in particular the relationship between the "insurance savings clause" and the "deemer clause." *Id.* at 740-41.

Specifically, this Court defined the reach of the insurance savings clause by determining the scope and purpose of the "deemer clause." The purpose of the "deemer clause," as decided in *Metropolitan Life*, is this:

[T]he deemer clause makes explicit Congress' intention to include laws that regulate [the terms of] insurance contracts within the scope of the insurance laws preserved by the savings clause. Unless Congress intended to include laws regulating insurance contracts within the scope of the insurance savings clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans.

*Id.* at 741 (emphasis added).<sup>17</sup> Accordingly, state laws regulating the terms of insurance contracts, such as the anti-subrogation statute in the instant case, are explicitly

<sup>16</sup> Massachusetts conceded that the "mandated-benefits" statute at issue could not be applied to self-funded benefit plans in light of the "deemer clause." See *Id.* at 735 n.14.

<sup>17</sup> Ironically, the Court of Appeals below acknowledged and cited with approval this language from *Metropolitan Life*, but proceeded to ignore it in reaching its novel result. (A17)

exempted "from the saving clause [and thus preempted by ERISA] when they are applied directly to benefit plans." *Id.*<sup>18</sup>

This Court's analysis in *Metropolitan Life* established a bright-line test: If a benefit plan is self-funded, state insurance laws are preempted. As the Court stated:

Our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing, we merely give life to a distinction Congress is aware of and one it has chosen not to alter.

*Metropolitan Life*, 471 U.S. at 747 (footnote omitted). The Court of Appeals' dismissal of this language as *dictum* is plainly unwarranted.

This Court not only concluded that ERISA preempts state insurance laws applied directly to benefit plans, see *id.* at 741, 747, but also expressly considered in *Metropolitan Life* some of the same legislative history upon which the Third and Sixth Circuits based their contrary decisions in *FMC* and *Northern Group Services*. Compare *id.* at 745-46 nn.23-24 with *FMC*, 885 F.2d at 87, and *Northern Group Services*, 833 F.2d at 93 n.3. Nowhere, however, did this Court mention the concern so prominent in the *FMC* and *Northern Group Services* opinions, i.e., that by use of the "deemer clause" Congress sought to prevent only "back-door" or "pretextual" attempts by the states to

<sup>18</sup> Section 1720 of the Pennsylvania Motor Vehicle Law regulates the terms of insurance contracts as certainly as the mandated benefits provision in *Metropolitan Life* did - only Section 1720 limits the types of permissible provisions instead of requiring certain additional provisions.

regulate ERISA plans. See *FMC*, 885 F.2d at 86-88; *Northern Group Services*, 833 F.2d at 92-93. Accordingly, the only logical conclusion is that the outcome-oriented analysis of the legislative history undertaken by the Third and Sixth Circuits is incorrect. Therefore, this Court should exercise its jurisdiction to prevent the perpetuation of the Third Circuit's misunderstanding of *Metropolitan Life*.

### 3. This Case Presents an Important and Recurring Question of Law.

This Court should exercise its jurisdiction to correct the Court of Appeals' erroneous decision in *FMC* because the pernicious effects of *FMC* and *Northern Group Services* will significantly and adversely affect the administration of thousands of self-funded benefit plans.

First, the Court of Appeals below adopted its test for restricting the scope of the "deemer clause" despite acknowledging that Congress had considered and flatly rejected precisely such a formulation with respect to defining the scope of Section 514(a), ERISA's broad preemption clause, because "it raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation." *FMC*, 885 F.2d at 88 (quoting Senator Javits).<sup>19</sup> Thus, *FMC* and *Northern Group*

<sup>19</sup> Senator Javits, one of the architects of ERISA, explained that Congressmen viewed earlier versions of House and Senate bills defining the perimeters of preemption in relation to the areas regulated by ERISA as problematic since "[s]uch a formulation raised the possibility of endless litigation over the

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Services invite precisely the type of endless litigation that ERISA's drafters sought to preclude.

Second, as the Court of Appeals below conceded, central to Congress' efforts in drafting the broad preemption provision was the goal of achieving federally uniform regulation of employee benefit plans. *FMC*, 885 F.2d at 88.<sup>20</sup> Congress believed that by preempting the field, but for certain specified exceptions like the savings clause, it had achieved its goals of encouraging employers to establish benefit plans and of protecting benefit plan participants and beneficiaries from encroachments on their plans by eliminating the threat of conflicting and inconsistent state and local regulation.<sup>21</sup> The tests

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validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." 120 Cong. Rec. 29942 (1974). To prevent this from occurring, Congress deliberately made the preemption provisions expansive in scope, as this Court observed in *Pilot Life*.

<sup>20</sup> See also 120 Cong. Rec. 29942 (1974) (statement of Senator Jacob Javits) ("[T]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required - but for certain exceptions - the displacement of State action in the field of private employee benefit programs") and 120 Cong. Rec. 29933 (1974) (statement of Sen. Harrison Williams, Jr.) (preemption of the field intended to apply in its broadest sense with only the exceptions specified in the act).

<sup>21</sup> See Staff of Senate Comm. on Labor and Public Welfare, 94th Cong. 2d Sess., Legislative History of ERISA 4670 (Comm.

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adopted by the Third and Sixth Circuits undercut these Congressional goals by requiring courts to engage in a case-by-case, outcome-oriented analysis that will prove a useful vehicle for the application of conflicting and inconsistent state laws to employee benefit plans. The likelihood of such outcome-oriented analysis is vividly illustrated by the Sixth Circuit's decision in *Liberty Mutual*, where the Sixth Circuit panel purportedly applied the test set forth in *Northern Group Services* but reached an opposite conclusion regarding the preemption of the same Michigan insurance statute at issue in *Northern Group Services*. See *Liberty Mutual*, 879 F.2d at 1387-88.

Third, both Courts of Appeals ignored the fact that Congress established benefit plan regulation as exclusively a federal concern to minimize the need for interstate employers such as FMC to administer their plans differently in each state in which they have employees. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983). Congress recognized the administrative realities of employee benefit plans and sought to promote an employer's capacity to provide benefits to employees scattered throughout many states in the most efficient manner, i.e., through a single employee benefit plan.

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Print 1976) (statement of U.S. Rep. John Dent) ("I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent state and local regulation.")

*Shaw*, 463 U.S. at 105 n.25. As this Court stated in *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 11 (1987):

It is thus clear that ERISA's preemption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Preemption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

At the ultimate expense of plan participants and beneficiaries, the Court of Appeals' holding below will indubitably subject the Health Plan to conflicting or inconsistent state laws.<sup>22</sup> Indeed, FMC's Health Plan itself has already been subjected to conflicting decisions regarding the application of state anti-subrogation laws. A district court in California held, in direct conflict with this case, that a California anti-subrogation statute is preempted as applied to FMC's Health Plan. *See Good*

<sup>22</sup> The Court of Appeals' opinion below paves the way for a direct assault on the fiscal integrity of self-funded plans, such as that operated by FMC. The Health Plan regenerates itself through subrogation, and the inability to exercise this contract right, because of the Motor Vehicle Law's anti-subrogation provision, may force the Health Plan to reduce benefits to participants and beneficiaries. Congress feared this very scenario and drafted ERISA's preemption provisions with a broad brush to prevent its occurrence.

*Samaritan, supra*. (D1) It is precisely this burden, to both plans and participants, that ERISA's preemption provisions are intended to avoid. *See, Fort Halifax*, 482 U.S. at 10.

Finally, a decision in this case will affect the operation of thousands of self-funded plans and the rights of millions of plan participants. Outcome-oriented tests and analyses, such as those created and utilized in the Third and Sixth Circuits, not only undermine the Congressional goal of a federal, uniform system of health benefit administration, but also will ultimately lead to the restriction of plan benefits – or to the crippling of plans themselves – to the potential detriment of millions of American workers. Congress clearly did not intend such a result.

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## CONCLUSION

For the foregoing reasons, a writ of certiorari should issue to the United States Court of Appeals for the Third Circuit.

December 29, 1989      Respectfully submitted,

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**APPENDIX A**

**FMC CORPORATION, Appellant,**

**v.**

**Cynthia Ann HOLLIDAY, Appellee.**

**No. 89-3226.**

United States Court of Appeals,  
Third Circuit.

Argued July 25, 1989.

Decided Sept. 11, 1989.

Employer which operated health plan and which employed father of injured motor vehicle passenger appealed from an order of the United States District Court for the Western District of Pennsylvania, Alan N. Bloch, J., granting summary judgment in favor of passenger in employer's action seeking declaratory judgment that it was entitled to subrogation against passenger's recovery for personal injuries. The Court of Appeals, Gibbons, Chief Judge, held that: (1) employer's subrogation claim was barred by Pennsylvania Motor Vehicle Financial Responsibility Law, and (2) anti-subrogation provision of statute was not preempted by ERISA.

Affirmed.

Charles Kelly [argued], H. Woodruff Turner, Stephen M. Rosenblatt, Kirkpatrick and Lockhart, Pittsburgh, Pa., for appellant.

Thomas G. Johnson [argued], Malcolm & Johnson, Indiana, Pa., for appellee.

Before GIBBONS, Chief Judge, HUTCHINSON, Circuit Judge and WOLIN, District Judge\*.

### OPINION OF THE COURT

GIBBONS, Chief Judge:

FMC Corporation appeals from a summary judgment in favor of the defendant Cynthia Ann Holliday, in FMC's action seeking a declaratory judgment that it is entitled to subrogation against Ms. Holliday's recovery for personal injuries received in an automobile accident. FMC is an employer operating a health plan and employs Ms. Holliday's father. She was permanently injured, and FMC has paid and will in the future pay her medical expenses pursuant to that plan. The district court held that under Pennsylvania law FMC had no subrogation rights, and that Pennsylvania law was not preempted by section 514 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1144. FMC contends the district court erred in both respects. We will affirm.

#### I.

On January 16, 1987, Ms. Holliday, then age 15, was seriously and permanently injured while riding as an automobile passenger in Indiana County, Pennsylvania. Her medical expenses to date exceed \$178,000 and the cost of future care is unknown. At the time of the accident her father owned an automobile policy issued by State Farm Mutual Automobile Insurance Company, which

\*Hon. Alfred M. Wolin, United States District Judge for the District of New Jersey, sitting by designation.

paid the first \$10,000 of his daughter's medical bills. Mr. Holliday also commenced a negligence action on behalf of his daughter in the Court of Common Pleas of Indiana County against Robert Lyons, the driver of the car in which she was a passenger at the time of the accident. That case proceeded to an eventual settlement on September 3, 1987, under which Lyons interpleaded his \$100,000 automobile liability policy in favor of Ms. Holliday and three other claimants injured in the accident. Ms. Holliday's recovery was limited to \$49,875.50 plus accrued interest.

At the time of the accident Mr. Holliday was also a covered employee under FMC's Salaried Health Plan, which provided benefits for dependents. That plan contains coordination of benefits clauses as follow:

If you or a covered member of your family are eligible to receive benefits under another group medical plan, Health Maintenance Organization (HMO), government plan, or by "no-fault" automobile insurance which provides medical coverage, you may be eligible for benefits from those Plans and your FMC plan. In the case of coverage by "no-fault" automobile insurance, FMC will pay covered expenses not paid for by no-fault insurance.

\* \* \*

#### No-Fault

In some states with no-fault motor vehicle coverage, the carrier is the primary insurer in these jurisdictions. All medical expenses related to an accident must be submitted to the carrier and not the FMC Health Care Plan. Eligible expenses not paid for by no-fault insurance *will* be paid by the FMC Plan.

Relying on these clauses FMC commenced paying Ms. Holliday's medical expenses only when the \$10,000 no-fault coverage under her father's State Farm automobile policy was exhausted. That \$10,000 is not in dispute.

The FMC Salaried Health Plan also contains a subrogation clause as follows:

The FMC self insured benefit program is automatically assigned the right of action against third parties in any situation in which benefits are paid to employees or their dependents. If you bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled you must reimburse the Plan for the benefits provided. You are obligated to avoid doing anything which would prejudice the Plan's rights of reimbursement, and you are required to sign and deliver documents to evidence or secure those rights. *Unless you sign the Company's "third party reimbursement form," the Claims Administrator will not process any claim where there is possible liability on behalf of a third party.*

(emphasis supplied). In order to obtain reimbursement of medical expenses in excess of \$10,000, Mr. Holliday signed a third-party reimbursement form, and the Salaried Health Plan thereafter paid his daughter's medical expenses.

When FMC learned of the negligence action in Indiana county it notified the Hollidays that it intended to exercise its subrogation rights with respect to that liability claim. The Hollidays responded that 75

Pa.Cons.Stat.Ann. § 1720 of the Pennsylvania Motor Vehicle Law prohibits such subrogation. This declaratory judgment action followed.

## II.

FMC contends that the court erred in holding that the exercise of its subrogation rights is barred by the relevant Pennsylvania law. The governing statute is the Pennsylvania Motor Vehicle Financial Responsibility Law, Act of Feb. 12, 1984, No. 11, § 3, 1984 Pa.Laws 28, as amended by Act of Feb. 12, 1984, No. 12, § 3, 1984 Pa. Laws 53, 75 Pa. Cons.Stat.Ann. §§ 1701-1798 (Purdon 1988), which is a comprehensive effort to establish a uniform system for the prompt payment of economic losses suffered by victims of vehicular collisions, including coverage for medical expenses arising out of the maintenance or use of a motor vehicle. *See Pennsylvania Legislative Journal*, 167th Sess., Oct. 4, 1983, at 1147 (comments of Sen. Holl); *id.*, 167th Sess., Dec. 14, 1983, at 2241 (comments of Rep. Manderino). Two provisions of the Motor Vehicle Law bear directly on this case: section 1720, which bars the assertion of subrogation rights; and section 1719, which helps define the scope of section 1720.

Section 1720 precludes subrogation with reference to a broad range of insurance arrangements:

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating



to availability of adequate limits) or benefits in lieu thereof paid or payable under section 1719 (relation to coordination of benefits).

75 Pa.Cons.Stat. Ann. § 1720 (emphasis added). The coordination of benefits provision reads:

(a) *General rule.* – Except for workers' compensation, a policy of insurance issued or delivered pursuant to this sub-chapter shall be primary. Any program, group contract or other arrangement for payment of benefits such as described in section 1711 (relating to required benefits) 1712(1) and (2) (relating to availability of benefits) or 1715 (relating to availability of adequate limits) shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in section 1711, 1712 or 1715 or workers' compensation.

(b) *Definition.* – As used in this section the term "program, group contract or other arrangement" includes, *but is not limited to*, benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

75 Pa.Cons.Stat. Ann. § 1719 (emphasis added).

The FMC Salaried Health Plan clearly falls within the plain meaning of section 1719. First, the Motor Vehicle Law elsewhere defines the term "benefits" to include "medical benefits". 75 Pa.Cons.Stat. Ann. § 1702. Second, section 1719(b) expressly employs non-exclusive language in defining the types of programs the statute covers. Finally, FMC effectively availed itself of section

1719's coordination of benefits formula in the Salaried Health Plan's parallel clauses quoted above. FMC's counterarguments are without merit. In a reading anything but plain, the corporation contends that the use in section 1719 of the phrase "group contract," an insurance term of art, indicates a clear intent to regulate only entities whose primary purpose is providing insurance or health care services. In itself a questionable interpretation of the term "group contract," FMC's argument ignores section 1719's use of two other patently non-exclusive terms, namely, "program" and "other arrangement." ERISA uses the terms "plan, fund or program" to define ERISA plans, 29 U.S.C. § 1002(1); the phrase "other arrangements" could scarcely be more broad on its face.

Pointing to the fact that subrogation is a long-established principle in Pennsylvania law, FMC urges that the Financial Responsibility law should be presumed not to have made any change in that principle unless the legislature was more specific. That position, however, is inconsistent with Pennsylvania's statute on statutory interpretation providing, at least since 1937, that statutes in derogation of the common law in general "be liberally construed to effect their objects and promote justice." 1 Pa.Cons.Stat. Ann. § 1928(c) (Purdon 1989).<sup>1</sup> FMC's

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<sup>1</sup> Pennsylvania's statute on statutory interpretation does provide for strict construction for certain categories, but the Motor Vehicle Law falls into none of them. The full provision reads:

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reliance on *Commonwealth v. Miller*, 469 Pa. 24, 364 A.2d 886, 887 (1987), moreover, is unavailing since that case

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§ 1928. Rule of strict and liberal construction

(a) The rule that statutes in derogation of the common law are to be strictly construed, shall have no application to the statutes of this commonwealth enacted finally after September 1, 1937.

(b) All provisions of a statute of the classes hereafter enumerated shall be strictly construed:

- (1) Penal provisions.
- (2) Retroactive provisions.
- (3) Provisions imposing taxes.
- (4) Provisions conferring the power of eminent domain.
- (5) Provisions exempting persons and property from taxation.
- (6) Provisions exempting property from the power of eminent domain.
- (7) Provisions decreasing the jurisdiction of a court of record.
- (8) Provisions enacted finally prior to September 1, 1937 which are in derogation of the common law.

(c) All other provisions of a statute shall be liberally construed to effect their objects and to promote justice.

1 Pa.Cons.Stat. Ann. § 1928 (Purdon 1988).

deals with criminal statutes, which as a class are among the exceptions to be strictly construed. It is well settled that insurance statutes, in contrast, fall into the primary class and are meant for liberal interpretation. *Antanovich v. Allstate Ins. Co.*, 320 Pa.Super. 322, 327, 467 A.2d 345, 348 (1983), *aff'd*, 507 Pa. 68, 488 A.2d 571 (1985); *Miller v. United States Fidelity & Guar. Co.*, 304 Pa.Super. 43, 54, 450 A.2d 91, 97 (1982), *aff'd*, 503 Pa. 127, 468 A.2d 1097 (1983).

FMC's alternative argument from statutory interpretation, that the Financial Responsibility Law employs language making it more restrictive than its predecessor statute, fares no better. The earlier act, the Pennsylvania No-fault Motor Vehicle Insurance Act of 1974, Pa.Stat. Ann. tit. 40, §§ 1009.101-1009.701 (Purdon 1989) (repealed), contained sweeping antisubrogation language. Under section 1009.111(a)(4) of the No-fault Act, "[i]n no event shall any entity providing benefits other than no-fault benefits to an individual as described in section 203 of this act, [Section 1009.203 of this title] have any right of subrogation with respect to said benefits." FMC attempts to make use of the alteration of this wording by first noting the common sense rule-of-thumb that different words in a subsequent statute on the same or a related topic indicate that the legislature must have intended a different meaning. *Klein v. Republic Steel Corp.*, 435 F.2d 762, 765-66 (3d Cir.1970). It then argues that the manifestly narrower language of the antisubrogation provision in the current Motor Vehicle law betokens an intent to excuse self-insured health care benefit programs such as FMC's. These arguments must be rejected. The current statute's use of the terms "program, group contract or other arrangement" appears hardly less broad than the



"any entity" language of the No-fault Law. Moreover, nothing in either the statute or the legislative history indicates any substantive intent to exclude programs like the FMC plan from the ambit of the bar to subrogation. The scant legislative history that does exist indicates, to the contrary, a desire to apply the prohibition broadly for the sake of uniformity and consistency. See *Pennsylvania Legislative Journal*, 167th Sess., Oct. 4, 1983, at 1147 (comments of Sen. Holl); *id.*, 167th Sess., Dec. 14, 1983, at 2241 (comments of Rep. Manderino).

We hold, therefore, that the district court did not err when it ruled that FMC's subrogation claim is barred by the Pennsylvania Financial Responsibility Law. That holding requires that we address FMC's preemption contention.

### III.

FMC, relying on *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F.2d 1157 (9th Cir.1986), contends that section 514 of ERISA categorically exempts from state regulation all self-funded employee benefit programs, and that such preemption reaches state law modifications of the common law of subrogation. Ms. Holliday, relying on *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir.1987), contends that Congress did not intend such categorical preemption. Rather, she urges, Congress intended to shield employee benefit programs only from state law that encroaches on ERISA concerns in the guise of insurance regulation. The question of preemption by ERISA of statutory changes in subrogation

law, when those changes are effected by state no-fault insurance statutes, has not been presented to this court.<sup>2</sup>

ERISA's section 514, 29 U.S.C. § 1144, is hardly a model of legislative draftsmanship. The section deals with preemption, but congressional intention must be gleaned from the interrelationship among a "preemption" clause, a "savings" clause, and a "deemer" clause.

The "preemption" clause broadly provides, in relevant part:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .

29 U.S.C. § 1144(a). The "savings" clause, however, appears to restore virtually all the state regulation that the "preemption" clause invalidates, at least so far as insurance laws are concerned. This provision states:

Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any persons from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(2)(A). Finally, the "deemer" clause in subparagraph (B) apparently brings the reader full circle

<sup>2</sup> FMC contends that *Insurance Board of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987), requires a decision in its favor. The issue before us was not addressed in that case.

by exempting employee benefit plans from state insurance regulation:

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B).

The resulting interpretive difficulties were summarized by the Court of Appeals for the Sixth Circuit, which observed:

The difficult problem in interpreting the preemption portion of ERISA § 514, 29 U.S.C. § 1144 is defining the scope of each of the three critical clauses so that each has a meaning and so that benefit obligations are governed by a rational system of state law and federal common law. Congress indicated its intention only in a very general way and left to the federal courts the problem of developing on a case-by-case basis principles of preemption of state law.

*Northern Group Services*, 833 F.2d at 89. Stating the obvious more than providing guidelines for surmounting these difficulties, the Supreme Court has set forth a three-part preemption test that mirrors each of the three provisions. Under this test a court must inquire whether a state law (1) relates to an employee benefit plan; (2) regulates insurance, and (3) survives the "deemer" clause. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-747, 105 S.Ct. 2380, 2388-2393, 85 L.Ed.2d 728 (1985).

#### A. The "Preemption Clause"

Neither party, nor any court that has dealt with the matter, disputes that the "relates to" language of the preemption clause should be read broadly in general, and broadly enough in particular to cover state no-fault automobile insurance plans. See *Northern Group Services*, 833 F.2d at 87-89. Only the Pennsylvania Trial Lawyers Association, as amicus curiae, suggests otherwise.

The command of the preemption clause that ERISA must preempt "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" suggests a wide application on its face. The Supreme Court sanctioned the plain meaning approach in *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-98, 103 S.Ct. 2890, 2899-2901, 77 L.Ed.2d 490 (1983). Holding that a state law directing health insurers to provide mental health care benefits "clearly" related to ERISA, the Court opined that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw*, 463 U.S. at 96-97, 103 S.Ct. at 2900; *Metropolitan Life*, 471 U.S. at 739, 105 S.Ct. at 2388. Moreover, if the preemption clause had been intended to be read narrowly, the remaining two clauses would have been unnecessary. *Northern Group Services*, 833 F.2d at 89.

Despite their split in outcome, the two Courts of Appeals that have considered antisubrogation laws concur in following *Shaw*. The Sixth Circuit held that Michigan's No-Fault Automobile Insurance Act, and



specifically the statute's coordination of benefits provisions, "directly . . . allocate[d] obligations to make insurance payments contrary to the express coordination-of-benefits language of the [ERISA] plan." *Northern Group Services*, 833 F.2d at 89. In consequence, "[h]olding that this state law does not 'relate to' the plan would run contrary to the plain meaning of the text and to the relevant case law and legislative history." *Id.* Similarly, in *Pacyga* the Court of Appeals for the Ninth Circuit had no difficulty in determining that Arizona's common law rule against subrogation also "relate[d] to" ERISA plans, this despite the Court's ultimate use of the deemer clause to find preemption nonetheless.<sup>3</sup> 801 F.2d at 1160. No other holdings so squarely address the preemption clause aspect of this case.

The Pennsylvania Trial Lawyers nonetheless argue for a more limited application of the preemption clause, relying on cases less apposite than *Shaw*. In the first, the Supreme Court held that Georgia's general garnishment statute did not "relate to" ERISA benefit plans. *Mackey v. Lanier Collections Agency & Ser.*, \_\_\_ U.S. \_\_\_, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988). Far from overruling *Shaw* and *Metropolitan Life*, *Mackey* instead finessed a narrow

<sup>3</sup> The *Pacyga* Court also noted that the Arizona subrogation rule "purported to regulate" ERISA plans as well, a further requirement for finding that a state law "relates to" ERISA. 801 F.2d at 1160. This additional requirement is evidently peculiar to the Ninth Circuit, *Martori Bros. Distributors v. James-Massengale*, 781 F.2d 1349, 1359 (9th Cir.1986), though the Second Circuit uses a version of the "purports to regulate" test to define the regulating "State" under 29 U.S.C. § 1144(c)(2), see *Rebaldo v. Cuomo*, 749 F.2d 133, 137-38 & n. 1 (2d Cir.1984).

exception. The majority, in the face of a four-justice dissent, reasoned that since creditors of ERISA plans are commonly allowed to bring state civil law actions and employ state methods of enforcing judgments, the creditors of plan participants should be able to do the same. *Mackey*, 108 S.Ct. at 2186-89. However questionable its logic, the *Mackey* court's exception to the Court's usual reading of the preemption clause rested exclusively on state laws dealing with the enforcement of civil judgments. The other cases offered are even less on point. Just prior to *Mackey*, the Supreme Court held that a Maine statute mandating a one-time severance payment in the event of a plant closing also did not, in ERISA's words, "relate to any employee benefit plan." *Fort Halifax Packing Co. v. Coyne*, 482 U.S.1, 107 S.Ct. 2211, 96 L.Ed.2d 1 (1987). The *Coyne* Court, however, took pains to distinguish statutes that would affect an ERISA plan on an ongoing basis from those affecting a one-time payment. 107 S.Ct. at 2220; see *Northern Group Services*, 833 F.2d at 88-89. No more compelling is the Trial Lawyers' reliance on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir.1984). There the Court of Appeals for the Second Circuit held that ERISA did not preempt a state plan regulating hospital insurance rates that only incidentally touched pension plans. This outcome simply accords with *Shaw's* common sense dictum that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." 463 U.S. at 100 n. 21, 103 S.Ct. at 2901 n.21.

Thus we reject the amicus position that the preemption clause should be read narrowly. It is broad enough to cover state antisubrogation laws.

### B. The "Savings Clause"

Both parties and the amicus agree that the type of antisubrogation provision found in the Pennsylvania Financial Responsibility Law "regulates insurance" within the meaning of the savings clause. This position accords with the two Circuits that have considered the matter. *Northern Group Services*, 833 F.2d at 89-90; *Pacyga*, 801 F.2d at 1160-61. It also accords with the clause's plain meaning and statutory structure, and with formal standards for interpreting general insurance provisions, as developed by the Supreme Court.<sup>4</sup> We agree that Pennsylvania's Financial Responsibility Law plainly "regulates insurance" within the meaning of the savings clause. The statute's coordination of benefits and antisubrogation provisions directly control the terms of insurance contracts. Application of the clause therefore clearly comports with the common sense view of statutory text extended to the savings provision in *Metropolitan Life*, 471

<sup>4</sup> Three years after ERISA's enactment a congressional oversight report noted:

In general these exemptions [to preemption] are designed to save state law as it is applied to entities which are not employee benefit plans . . . , to the extent that such regulation does not relate to employee benefit plans.

Subcomm. on Labor Standards, House Comm. on Educ. & Labor, ERISA Oversight Report of The Pension Task Force 8 (1977). As the Court of Appeals for the Sixth Circuit opined, "[t]hese subsequent legislators (or their staff) did not seem to recognize or consider the fact that the 'savings' clause would not be necessary at all if it only saves state laws that do not 'relate to' ERISA plans." *Northern Group Services*, 833 F.2d at 89.

U.S. at 740-43, 105 S.Ct. at 2389-2391. The Financial Responsibility Law also meets the further common sense requirement that a state law not merely affect some aspect of the insurance industry, but be specifically directed toward it. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 1554, 95 L.Ed.2d 39 (1987).

The placement within section 514 of the savings clause bolsters this common sense interpretation. The savings clause is followed directly by the deemer clause which states that an employee benefit plan shall not be deemed an insurance company "for purposes of any law of any State purporting to regulate . . . insurance contracts." 29 U.S.C. § 1144(b)(2)(B). "By exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause." *Metropolitan Life*, 471 U.S. at 741, 105 S.Ct. at 2389-2390. Insofar as the Financial Responsibility Law expressly regulates insurance contracts, it necessarily falls within the ambit of the savings provision.

Finally, the Supreme Court's standard for determining when a practice constitutes "the business of insurance," developed with reference to the McCarran-Ferguson Act of 1945, 15 U.S.C. §§ 1011-1015, removes any doubt that the Financial Responsibility Law "regulates insurance." Three factors are relevant to the determination:

*first*, whether the practice has the effect of transferring or spreading the policyholder's risk; *second*, whether the practice is an integral part of



the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

*Metropolitan Life*, 471 U.S. at 743, 105 S.Ct. at 2391 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct. 3002, 3009, 73 L.Ed.2d 647 (1982)). Every court that has applied these criteria to coordination of benefits requirements has found the first two criteria easily satisfied. See *Northern Group Services*, 833 F.2d at 90; *Pacyga*, 801 F.2d at 1161. While the Financial Responsibility Law does go beyond the third criterion insofar as it reaches any "program, group, or other arrangement" including health and hospital plans, its principal and substantial effect is nonetheless on the insurance industry. See *Northern Group Services*, 833 F.2d at 90; *Pacyga*, 801 F.2d at 1161.

### C. The "Deemer Clause"

The deemer clause, which states that no "employee benefit plan . . . shall be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts," creates an exception to the savings provision, which itself created an exception to the general preemption clause. 29 U.S.C. § 1144(b)(2)(B). Preemption in this case, therefore, turns on whether FMC's Salaried Health Plan falls within the deemer clause exception insulating employee plans from state regulation. Neither the statutory text, legislative history, nor case law provides a clear answer; this is one reason that the two courts of appeals which addressed it parted company on this precise point. Of the two solutions, *Northern Group Services* comes closer

to the correct interpretation, namely, that the deemer clause is meant mainly to reach back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation. See 833 F.2d at 91-94.

Support for this answer comes from the statutory text. The deemer clause protects ERISA plans from being deemed insurers, or otherwise in the business of insurance, by any state law "purporting" to regulate insurance. Remarks from two of the sponsoring senators support the view that the use of "purporting" betokens a congressional concern only for regulation that was merely a pretext for impinging upon ERISA plans. Senator Javits stated that broad Federal preemption meant to bar "[s]tate laws hastily *contrived* to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." 120 Cong.Rec. 29,942, reprinted in 3 Legislative History of the Employee Retirement Income Security Act of 1974, at 4770-71 (emphasis added). Senator Williams also displayed concern for pretextual state infringements, albeit in the context of professional regulation having the force of state law rather than state insurance laws themselves:

Consistent with th[e] principle [of broad preemption regarding any action that has the force or effect of law] State professional organizations acting under the *guise* of State-enforced professional regulation, should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized.

120 Cong.Rec. 23,933, reprinted in 3 Legislative History of the Employee Retirement Income Security Act of 1974, at



4746 (emphasis added). See *Northern Group Services*, 833 F.2d at 93 n. 3.

The legislative history more generally also offers support for a "pretextual" construction. Initially, both the House and Senate versions of the bill preempted only those state laws concerning ERISA's "fiduciary, reporting and disclosure responsibilities" or relating to "the subject matter" it was to regulate. Both versions also contained a savings clause for state insurance regulation, but neither contained any deemer provision. The first version of the deemer clause did not arise until the Houses replaced the language of the original H.R. 2 with that of H.R. 12,906 just prior to passage of the preconference bill. This new version, including a narrower progenitor of the preemption clause and an earlier model of the savings provision, read:

#### EFFECT ON OTHER LAWS

SEC. 514. (a) It is hereby declared to be the express intent of Congress that . . . the provisions of part 1 of this subtitle shall supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the reporting and disclosure responsibilities, and fiduciary responsibilities, of persons acting on behalf of any employee benefit plan to which part 1 applies.

(b) Nothing in part 1 of this subtitle shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities or to prohibit a State from requiring that there be filed with a State agency copies of

reports required by this title to be filed with the Secretary. No employee benefit plan subject to the provisions of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(c) It is hereby declared to be the express intent of Congress that the provisions of parts 2, 3, and 4 of this subtitle shall supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the non-forfeitability of participant's benefits in employee benefit plans . . . , the funding requirements for such plans, the adequacy of financing of such plans, portability requirements for such plans, or the insurance of pension benefits under such plans.

2 Legislative History of the Employee Retirement Income Security Act of 1974, at 2920-22 (emphasis added). The Senate version included no comparable deemer language.

Before the conference, the committee declared itself to be divided on whether the House version, with the deemer clause, should be adopted. As a compromise, "some of the staff" suggested that the language be incorporated, but only for a limited time subject to subsequent study. 3 Legislative History of the Employee Retirement Income Security Act of 1974, at 5283.

The conference bill combined these versions and recommendations in several ways. First, it adopted the current broad preemption provision without reference to specific core concerns of ERISA. Senator Javits explained that the change sprang from the concern that the more specific formulation "raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation," and a desire to err on the side of Federal uniformity. 120 Cong.Rec. 29,942, reprinted in 3 Legislative History of the Employee Retirement Income Security Act of 1974, at 4770. Second, the conference version retained the general savings language found in both the Senate and House bills. Finally, the conference committee decided to retain the deemer provision without any time limit but with a mandate for a later congressional study of the effects of Federal preemption.<sup>5</sup> 29 U.S.C. § 1222(a)(5).

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<sup>5</sup> The study that resulted, part of the 1977 Activity Report of the House Committee on Education and Labor, suggests an opposite interpretation of the deemer clause. According to the report:

the "deemed" language was utilized to create an irrebuttable presumption that these plans are not insurance, trust companies, etc., for purposes of state regulation. As a drafting technique the "deemed" is used in section 514(b) not to *bar* the use of a legal fiction by the states but to *create* what may amount to a legal fiction in a given circumstance. The irrebuttable presumption would not be overcome even if an employee benefit plan engages in activities which

(Continued on following page)

The net effect of these changes reinforces the view that Congress intended the deemer clause to protect core ERISA concerns within the context of the insurance regulation exception to preemption. The "purporting" language, present at the creation and previously dealt with, suggests that such concerns arose as early as H.R. 12,906. More important, the retention of the deemer clause in the face of the expanded preemption clause indicates that the deemer clause in effect was meant to do the more narrow, specified work which the original version of the preemption clause was meant to do. Read in this way the legislative history and the three clauses make sense: first, the preemption clause preempts nearly any state law relating to employee benefit plans; second, the savings clause carves out the narrow but sizable exception of state laws regulating insurance; and finally, the deemer clause guards against any insurance regulation that infringes on such ERISA areas as reporting, disclosure, and nonforfeitability.

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bring it within the insurance, trust, or securities activities generally regulated by a state.

Subcomm. on Labor Standards, House Comm. on Educ. & Labor, ERISA Oversight Report of the Pension Task Force 10 (1977) (emphasis in original).

As the Court of Appeals for the Sixth Circuit pointed out, however, a "*post hoc* explanation . . . is entitled to little weight when it conflicts with a reasonable interpretation of statutory text and prior legislative history." *Northern Group Services*, 833 F.2d at 92 (citing *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 117-18 & n. 13, 100 S.Ct. 2051, 2061 & n. 13, 64 L.Ed.2d 766 (1980)).

Remarks of Senator Javits support this reading. Although not an exclusive list, all the examples of state law that the senator considered subject to preemption dealt with matters central to ERISA, of the type enumerated in the original preemption clause:

In view of Federal preemption, State laws compelling disclosure from private welfare or pension plans, imposing fiduciary requirements on such plans, imposing criminal penalties on failure to contribute to plans – unless a criminal statute of general application – establishing State termination insurance programs, et cetera, will be superseded.

120 Cong.Rec. 29,942, reprinted in 3 Legislative History of the Employee Retirement Income Security Act of 1974, at 4771. Any reading other than one confined to the central aspects of ERISA would either have the deemer clause swallow the savings clause or read into the statute other distinctions that are not there.

The latter course is that followed by the *Pacyga* court and urged by FMC. In their view the deemer clause incorporates a bright line distinction between employee benefit plans that purchase insurance and those, like FMC's, which are self-insured. Plans that purchase insurance are subject to state regulation regardless of the deemer clause. Self-insured plans purportedly are not. See *Pacyga*, 801 F.2d at 1161.

The principal, if not sole, basis for this distinction is Supreme Court dicta. In *Metropolitan Life*, the Court upheld a Massachusetts law mandating that certain benefits be included in certain health plans. 471 U.S. 724, 105 S.Ct. 2380. The majority, reasoning that the state law

"regulated insurance" within the meaning of the savings clause, rejected the appellant's argument that the clause covered only direct regulation of traditional insurance activities. Apparently since the health plans at issue could not be considered ERISA employee benefit plans, the appellant did not assert an alternative deemer clause argument. The Court nonetheless stated:

We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.

*Metropolitan Life*, 471 U.S. at 747, 105 S.Ct. at 2393. For support the Court cited neither statutory text nor legislative history. Instead, relying on vague language in Congress' *post hoc* study the Court opined, in a footnote:

A 1977 Activity Report of the House Committee on Education and Labor recognized the difference in treatment between insured and non-insured plans:

"To the extent that [certain programs selling insurance policies] fail to meet the definition of an 'employee benefit plan' [subject to the "deemer clause"], state regulation of them is not preempted by section 514, even though such state action is barred with respect to the plans which purchase these 'products.'" H.R. Rep. No. 94-1785, p. 48. A bill to amend the saving clause to specify that mandated-benefit laws are preempted by ERISA was reported to the Senate in 1981 but was not acted upon.



*Metropolitan Life*, 471 U.S. at 747 n. 25, 105 S.Ct. at 2393 n. 25.

Both the *Pacyga* court and FMC rely almost entirely on the foregoing dicta. In *Pacyga*, the court held that ERISA preempted Arizona antisubrogation law with regard to self-insured employee benefit plans. The court reasoned that such plans fell within the protection of the deemer clause on the basis of the distinction set forth in *Metropolitan Life*. *Pacyga*, 801 F.2d at 1161-62. The *Pacyga* opinion's terse treatment lacks any reference to statutory text, structure, or history.<sup>6</sup> It simply points to the formal distinction made in the *Metropolitan Life* footnote. Importation of that formal distinction to a different content is not proper in the face of direct consideration of congressional intent. Nor, as the *Northern Group Services* opinion has pointed out, need there necessarily be a conflict. The distinction between insured and self-insured plans does not disappear. Rather, under *Metropolitan Life* insured plans would *per se* survive the deemer clause, while self-insured plans would merely be considered on a case-by-case basis as to whether the state regulation involved

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<sup>6</sup> Several other decisions have likewise imported the *Metropolitan Life* dicta, but the cases are distinguishable. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987); *Shiffler v. Equitable Life Assurance Soc'y*, 838 F.2d 78 (3d Cir.1988). None of these cases dealt with the history or purpose of the deemer clause. The reason they did not, moreover, was that the claims brought forward fell prey not to the deemer clause, but directly to the preemption clause because the state laws involved did not "regulate insurance" under the savings provision. See, e.g., *Pilot Life*, 481 U.S. at 57 & n. 4, 107 S.Ct. at 1558 & n. 4; *Shiffler*, 838 F.2d at 81-82.

affects a central concern of ERISA. *Northern Group Services*, 833 F.2d at 94-95.

In light of the available interpretive materials the proper inquiry under the deemer clause is whether the state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the preemption provision. The court, reviewing a state insurance law, should inquire whether that law conflicts with any substitute mandate in ERISA. The parties and the amicus have suggested no such conflict. Thus the savings clause applies and the deemer clause does not.

### III.

We have rejected FMC's contention that the anti-subrogation provision in the Pennsylvania Financial Responsibility Law is inapplicable and its contention that if that provision applies it is preempted. The judgment appealed from will therefore be affirmed.

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**APPENDIX B**

**UNITED STATES COURT OF APPEALS  
FOR THE THIRD CIRCUIT**

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No. 89-3226

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FMC CORPORATION,  
Appellant

v.

CYNTHIA ANN HOLLIDAY

---

**SUR PETITION FOR REHEARING**

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Present: GIBBONS, *Chief Judge*, HIGGINBOTHAM,  
SLOVITER, BECKER, STAPLETON, MANSMANN,  
GREENBERG, HUTCHINSON, SCIRICA, COWEN and  
NYGAARD, *Circuit Judges*, and WOLIN, *District Judge*\*

The petition for rehearing filed by Appellant in the above entitled case having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court in banc; the petition for rehearing is denied.

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\*District Judge Alfred M. Wolin as to panel rehearing only.

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By the Court,

/s/ John J. Gibbons  
Chief Judge

DATED: October 5, 1989

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## APPENDIX C

IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC CORPORATION, a	)	
corporation,	)	
	)	
Plaintiff,	)	Civil Action
	)	No. 88-1098
vs.	)	
CYNTHIA ANN HOLLIDAY,	)	
an individual,	)	
	)	
Defendant.	)	

## MEMORANDUM OPINION

BLOCH, District J.

Plaintiff and defendant having agreed that the material facts of this action are uncontroverted, this matter is before the Court on cross-motions for summary judgment. The material facts are as follows.

Defendant Cynthia Ann Holliday (Holliday) was seriously injured in an automobile accident in Indiana County, Pennsylvania, on January 16, 1987, when she was 15 years old. She required extensive medical treatment, costing in excess of \$178,000.

At all relevant times, Holliday's father was an employee of plaintiff FMC Corporation (FMC). As such, he subscribed to the FMC Salaried Health Care Plan (the Plan), a self-insured employee welfare benefit plan. Pursuant to the Plan, FMC paid a substantial amount in medical benefits toward Holliday's treatment.

The Plan contained a coordination of benefits provision, pursuant to which it coordinated its benefits with

those of other medical plans and "no-fault" auto insurance providing medical coverage. Thus, FMC did not pay any benefits until certain insurers, such as the Holliday's automobile insurance company, had paid the maximum amount that they would pay.

In addition, the Plan summary provides:

The FMC self insured benefit program is automatically assigned the right of action against third parties in any situation in which benefits are paid to employees or their dependents. If you bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled you must reimburse the Plan for the benefits provided. You are obligated to avoid doing anything which would prejudice the Plan's rights of reimbursement, and you are required to sign and deliver documents to evidence or secure those rights. Unless you sign the Company's "third-party reimbursement form," the Claims Administrator will not process any claim where there is possible liability on behalf of a third party.

(Plan summary, at 49). Gerald Holliday, defendant's father, had signed such a third-party reimbursement form.

On April 20, 1987, Gerald Holliday, as parent and natural guardian of the defendant, commenced a negligence action in the Court of Common Pleas of Indiana County, Pennsylvania, against the driver of the vehicle in which defendant was a passenger at the time of the accident. FMC has notified defendant that it intends to exercise its subrogation rights with respect to any amounts obtained as a result of this lawsuit. Defendant



Holliday contends that §1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 (the Pennsylvania law), 75 Pa.C.S.A. §1720, prohibits such subrogation. FMC argues that the Employee Income Retirement Security Act (ERISA) preempts the Pennsylvania law.

This Court may grant summary judgment "if the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). The parties in this case have agreed that there is no genuine issue as to any material fact. This Court holds that the defendant is entitled to judgment as a matter of law.

*I. The Pennsylvania law applies to the Plan*

Initially, of course, this Court must determine whether the Pennsylvania law would apply to the Plan at all. If §1720 would not prohibit FMC from obtaining subrogation, then this Court need not decide whether ERISA preempts that section. There would be no applicable Pennsylvania law which might be preempted.

Section 1720 of the Pennsylvania law, 75 Pa.C.S.A. §1720, provides:

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in

lieu thereof paid or payable under section 1719 (relating to coordination of benefits).

FMC clearly does not provide the required benefits or motor vehicle insurance referred to in §§1711, 1712 or 1715 of the Pennsylvania law, 75 Pa.C.S.A. §§1711, 1712, 1715. It does, however, provide the benefits referred to in §1719. This section provides:

(a) *General rule.* – Except for workers' compensation, a policy of insurance issued or delivered pursuant to this subchapter shall be primary. Any program, group contract or other arrangement for payment of benefits . . . shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in section 1711, 1712 or 1715 or workers' compensation.

(b) *Definition.* – As used in this section the term "program, group contract or other arrangement" includes, *but is not limited to*, benefits payable by a hospital plan corporation or a professional health service corporation. . . .

75 Pa.C.S.A. §1719 (emphasis added).

FMC contends that it is not a "program, group contract or other arrangement" under §1719 for two reasons. First, FMC argues that, because this section specifically lists certain types of corporations incorporated to provide health care benefits or services, only those "programs, group contracts or other arrangements" come within the section. To accept this reasoning would be to ignore the express language of the statute providing that those types of corporations are not the only types constituting a "program, group contract or other arrangement" under

§1719. The statute clearly states that the term "programs, group contracts or other arrangements" is not limited to the listed corporations.

Second, FMC contends that a comparison of §1720 to the subrogation provision of the prior Pennsylvania No-Fault Motor Vehicle Insurance Act (the No-Fault Act) indicates that the Pennsylvania legislature did not intend to prohibit subrogation on the part of entities such as the Plan. FMC notes that §111(a)(4) of the No-Fault Act provided that "[i]n no event shall *any entity* providing benefits other than no-fault benefits . . . have any right of subrogation with respect to said benefits." 40 P.S. §111(a)(4) (emphasis added). FMC claims that, by changing the description of those prohibited subrogation rights from "any entity" to "program, group contract or other arrangement," the legislature must have intended to exclude plans such as the one at issue from being affected by the subrogation provision.

It is true that when words of a later statute differ from those of a previous one on the same or a related subject, it is presumed that the legislature intended them to have a different meaning. *Klein v. Republic Steel Corp.*, 435 F.2d 762, 765-66 (3d Cir. 1970). It is not true, however, that this Court may assume that the different meaning intended is that which the plaintiff advocates. FMC attempts to convince this Court that the Court should make this assumption because, in another portion of the Pennsylvania law, the Pennsylvania legislature has afforded a right of subrogation to Assigned Claims Plans. 75 Pa.C.S.A. §1756.

Assigned Claims Plans are plans designed to provide medical benefits to, *inter alia*, people not entitled to receive first-party benefits under the Pennsylvania law. 75 Pa.C.S.A. §1752. FMC argues that the Pennsylvania legislature could not have intended to allow Assigned Claims Plans a right of subrogation but prohibit subrogation on the part of employee welfare benefit plans providing benefits in addition to first-party benefits.

It is entirely possible that this is exactly what the Pennsylvania legislature intended to do. Motor vehicle insurance companies are required by law to establish Assigned Claims Plans. Those who would recover under such plans may not be otherwise paying insurance premiums for their coverage. Furthermore, in these instances, the Assigned Claims Plans pay benefits instead of first-party benefits, because the recipients are not eligible to receive first-party benefits. In such an instance, the legislature may have intended to allow Assigned Claims Plans some right of subrogation while other entities, providing benefits in addition to first-party benefits, are not able to obtain subrogation. Without more convincing evidence that the Pennsylvania legislature did not intend §1720 to apply to employee welfare benefit plans, this Court will not read out of the statute the language which explicitly indicates that the term "program, group contract or other arrangement" includes more than certain types of health care or health service corporations.

Moreover, as defendant points out, FMC has availed itself of the benefits of the Pennsylvania law's "coordination of benefits" provision as set forth at §1719. FMC required that the Hollidays' motor vehicle insurer pay up to its policy limits before FMC would provide benefits.

Thus, by its own actions, FMC has indicated that it is the type of entity referred to in §1719.

Thus, if it is not preempted, §1720 of the Pennsylvania law would prohibit FMC's exercise of subrogation rights in any amount Holliday recovered in the case in the Indiana County court.

## II. ERISA'S preemption provisions

Section 1514(a) (sic) of ERISA, 29 U.S.C. §1144(a), provides generally that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." There is one exception to this broad preemption provision, contained in a "savings clause," providing:

Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(2)(A).

The savings clause does not automatically exempt all state laws regulating insurance from preemption, however, because it is modified by the so-called "deemer clause," which provides:

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of

any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. §1144(b)(2)(B).

Thus, in order to determine whether ERISA preempts the Pennsylvania law in this case, this Court must first determine whether the Pennsylvania law relates to an employee benefit plan. Next, this Court must determine whether, even if the Pennsylvania law relates to an employee benefit plan, it is exempted from preemption by the savings clause because it regulates insurance. Finally, if the answers to the first two inquiries are affirmative, this Court must determine whether the "deemer clause" nevertheless operates to prevent the Pennsylvania law from being saved from preemption. *See Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 45 (1987).

### A. The Pennsylvania law "relates to" the Plan

A state law relates to an employee benefit plan if it has a connection with or reference to such a plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). Preemption is not limited to state laws specifically designed to affect employee benefit plans. *Id.* at 98. Instead, ERISA preempts even common-law causes of action which seek remedies for improper processing of a claim for benefits under an ERISA plan. *Pilot Life*, 481 U.S. at 48.

FMC argues that §1720 of the Pennsylvania law does not "relate to" the Plan because the Pennsylvania legislature did not intend this provision to apply to employee welfare benefit plans such as the plan at issue. This



argument is without merit. This Court has already determined that the Pennsylvania law does indeed apply to the Plan.

Furthermore, the Pennsylvania law need not have been specifically designed to affect employee benefit plans to relate to such plans. *Shaw*, 463 U.S. at 98. The phrase "relate to" has been given the broadest common-sense meaning. *Shiffler v. Equitable Life Assurance Society of the United States*, 838 F.2d 78, 81 (3d Cir. 1988). Therefore, as long as a lawsuit would have a connection with an employee benefit plan, it relates to it so that any state causes of action upon which the suit is based are preempted.

Finally, this Court notes that it would be anomalous for FMC to assert that the law does not relate to the Plan when FMC is the party asserting preemption. ERISA preempts state law only if that law relates to an employee benefit plan. Thus, this Court must assume that FMC's statement that it will only "assume *arguendo*" that the Pennsylvania law relates to the Plan was inserted into FMC's brief merely in order to preserve FMC's argument that the law does not apply to the Plan in the first place.

#### B. *The Pennsylvania law regulates insurance*

To determine whether a state law regulates insurance, this Court must examine the law both to determine whether it comports with a common-sense understanding of the phrase "regulates insurance" and to ascertain whether it affects the business of insurance as that business is defined in the McCarran-Ferguson Act. See *Pilot*

*Life*, 481 U.S. at 50-51; *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 743 (1985). No one factor is dispositive; rather, each is instructive. *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 129 (1982); *Insurance Board Under Social Insurance Plan of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 411 (3d Cir. 1987); *United Food and Commercial Workers v. Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986).

In this case, the parties have agreed that this law regulates insurance. Thus, the Pennsylvania law is saved from preemption by 29 U.S.C. §1144(b)(2)(A), unless the "deemer clause" prohibits the law from being saved from preemption.

#### C. *The deemer clause does not operate to bring the Pennsylvania law back within the scope of ERISA preemption*

As previously noted, the deemer clause provides that state laws purporting to regulate insurance may not directly regulate employee benefit plans by "deeming" them to be insurance companies for the purposes of such laws. *Pilot Life*, 481 U.S. at 45. The Plan at issue is a self-insured plan. That is, FMC does not provide benefits for its employees by taking out a group insurance policy with an insurance company. Instead, FMC provides the funds needed to pay any medical benefits due under the Plan out of its own assets.

FMC contends that to apply the Pennsylvania law to a self-insured plan, one must first "deem" the plan to be an insurance company. Thus, such application of the Pennsylvania law would violate the deemer clause. As a

result, the Pennsylvania law as it applies to self-insured plans is preempted, even though it regulates insurance.

Following this reasoning, a number of courts have held that certain state laws regulating insurance are nonetheless preempted as they apply to self-insured plans. See, e.g., *Pacyga*, 801 F.2d 1157 (Arizona anti-subrogation law preempted as applied to self-insured plans); *Powell v. Chesapeake and Potomac Telephone Co.*, 780 F.2d 419 (4th Cir.), cert. denied, 476 U.S. 1170 (1986) (common-law claims relating to mishandling of benefits requests preempted as applied to self-insured plan); *Children's Hospital v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985) (Louisiana anti-discrimination benefits statute preempted as applied to self-insured plans); *Kilmer v. Central Counties Bank*, 623 F. Supp. 994 (W.D. Pa. 1985) (portion of No-Fault Act permitting double recovery of benefits preempted as applied to self-insured plans).

Application of this reasoning would result in certain employee benefit plans being free from state laws regulating insurance merely because they chose to self-insure. Indeed, the Supreme Court itself has stated in *dicta* that, through the deemer clause, Congress has distinguished between insured and self-insured plans in such a way. "By doing so we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." *Metropolitan Life*, 471 U.S. at 747 (footnote omitted). See also *Board of Trustees of Montana Teamsters Employers v. Coyne*, 628 F. Supp. 561, 564 (D. Mont. 1986).

On the contrary, however, it is possible to read the three interlocking preemption provisions of ERISA – the

preemption section, the savings clause and the deemer clause – to give life to the deemer clause yet not presume that Congress intended to make an illogical distinction between insured and self-insured plans. In *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir.), cert. denied, 108 S.Ct. 1754 (1988), the Sixth Circuit Court of Appeals held that the deemer clause does not automatically immunize self-insured employee benefit plans from state laws regulating insurance. 833 F.2d at 91. In *Northern Group Services*, certain employee benefit plans, some insured by others and some self-insured, attempted to make no-fault automobile insurers primarily liable and their own plans secondarily liable for benefits. When the no-fault automobile insurers objected, citing Michigan insurance law, the plans argued that the Michigan law was preempted, by virtue of the deemer clause in the case of the self-insured plans.

The Court noted that Congress has expressly declared in two different ERISA subsections that ERISA does not preempt state laws regulating insurance. *Id.*; see 29 U.S.C. §§1144(b)(2)(A); 1144(d). It stated:

In the face of this redoubled statutory preservation of the principle favoring state regulation of insurance, it appears contrary to the overall legislative purpose to read the deemer clause broadly to bar all state regulation of self-insured plans. In this area of traditional state regulation, "the presumption is against preemption."

833 F.2d at 92, quoting *Metropolitan Life*, 471 U.S. at 741.

The Court in *Northern Group Services* noted that the legislative history of the deemer clause was ambiguous.

In fact, certain portions of the legislative history indicate that Congress' central concern in adopting the ERISA preemption scheme was "to avoid intentional – and perhaps pretextual – attempts by states to restrict the discretion of ERISA plans to engage in practices that otherwise would be permitted by federal law." 833 F.2d at 93. In *Northern Group Services*, as in this case, the parties did not argue that the state was, intentionally or by pretext, attempting to focus specifically on ERISA plans in the statutes at issue.

The Court in *Northern Group Services* held:

In the absence of a showing of state purpose specifically to regulate the content of welfare benefits provided by ERISA, the effect of the deemer clause should be assessed by a balancing of the interests in federal uniformity against those of state primacy in the regulation of insurance.

*Id.*

The Court in *Northern Group Services* ruled that exempting self-insurers from the Michigan law requiring that insurers coordinate benefits so that no-fault automobile insurers were secondarily liable would disrupt the state's ability to administer a uniform scheme of coordination of benefits. Such disruption would frustrate the state's goal of cost containment, create unpredictability and possibly undermine the financial stability of no-fault insurers. Similarly, in this case, exempting self-insurers from the Pennsylvania law prohibiting subrogation would disrupt the state's ability to administer a generally uniform scheme of prohibiting subrogation, except in certain specific instances in which Assigned Claims Plans

are required by law to provide benefits to those who would not otherwise receive them. In those incidents, as a matter of equity, the state has chosen to permit subrogation. Otherwise, the state's uniform goal of prohibiting subrogation remains intact.

Furthermore, by holding that §1720 of the Pennsylvania law as applied to self-insured plans comes within the deemer clause and is thus preempted by ERISA, this Court would be permitting plans to ensure that they could obtain subrogation merely by deciding to self-insure.

Weighing this injury to the state scheme against the federal interest in uniform administration of ERISA plans, it is clear that the injury to the state scheme far outweighs any federal interest in developing a "federal common law" of subrogation rights of self-insured ERISA plans. This area of insurance law, like the area of coordination of benefits, has been developed by each state over a period of years. See 833 F.2d at 93-94. Injury to the state scheme would be especially great when federal law would encroach upon state law in an area in which states enjoy "general authority and autonomy" – insurance regulation. *Id.*

As noted in *Northern Group Services*, this approach does not necessarily contravene the *Metropolitan Life* dicta quoted earlier in this opinion. The rule enunciated by the Court in *Northern Group Services* and followed by this Court today preserves a distinction between plans insured by others and those which are self-insured. Insured plans are *per se* open to indirect regulation. Self-insured plans are subject to state regulation only when no



An appropriate Order will be issued.

Date: 3/14/89 /s/ Alan N. Bloch  
United States District  
Judge  
cc: Counsel of record.

AND NOW, this 14th day of March, 1989, upon consideration of Plaintiff's Motion for Summary Judgment filed in the above captioned matter on December 2, 1988, IT IS HEREBY ORDERED that said Motion is DENIED.

AND, further, upon consideration of Defendant's Motion for Summary Judgment filed in the above captioned matter on December 5, 1988, IT IS HEREBY ORDERED that said Motion is GRANTED.

/s/ Alan N. Bloch  
United States District  
Judge

cc: Charles Kelly, Esquire  
1500 Oliver Building, Pittsburgh, PA 15222

Thomas Johnson, Esquire  
406 Indiana Theatre Building, Indiana, PA 15701

## APPENDIX D

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF CALIFORNIA

FMC CORP. EMPLOYEE	)	
WELFARE BENEFITS PLAN	)	
COMMITTEE, et al.,	)	C-88-3092-FMS
Plaintiff(s),	)	ORDER GRANTING
	)	PARTIAL
v.	)	SUMMARY
	)	JUDGMENT
THE GOOD SAMARITAN	)	
HOSPITAL OF THE	)	(Filed December 5,
SANTA CLARA VALLEY,	)	1988)
Defendant(s).	)	

This is a motion for summary declaratory judgment on a part of the plaintiffs' claim. Plaintiffs request the Court to declare that they have a right to subrogate their claims to those of a third party against the defendant. The Court heard argument on the plaintiffs' motion regularly on November 16, 1988 at 10:00 a.m.

Summary judgment is proper only when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Sankovitch v. Life Ins. Co. of No. America*, 638 F.2d 136, 138 (9th Cir. 1981). In deciding a motion for summary judgment, the Court draws all inferences of fact in favor of the party opposing the motion. *Id.*; *Bieghler v. Kleppe*, 633 F.2d 531 (9th Cir. 1980). Defendant, in opposing plaintiffs' motion, has submitted no sworn affidavits or declarations. Nor has defendant made a motion under Fed. R. Civ. P. 56(f) indicating that it has not yet had the opportunity to gather the facts necessary to effectively controvert the facts asserted by the movant. Defendant

does attempt to catalogue a number of "triable issues of fact" in its brief in opposition to plaintiffs' motion. But it is well established that assertions made in legal memoranda and at oral argument are not evidence and cannot create issues of fact. *Flaherty v. Warehouseman Local 334*, 574 F.2d 484 (9th Cir. 1978). Thus, the Court finds no genuine issues of material fact as to those facts asserted in plaintiffs' declarations. Nevertheless, even where no evidence is presented in opposition to the motion, summary judgment should not be granted if the evidence in support of the motion is insufficient to entitle the movant to judgment as a matter of law. *Hoover v. Switlik Parachute Co.*, 663 F.2d 964, 967 (9th Cir. 1981).

## FACTUAL BACKGROUND

Plaintiffs are an employee welfare benefits plan (the "plan") and the committee entrusted with administering the plan. Defendant is in the business of providing health care. One of the employees covered by the plan, a Mrs. Lo Nero, has sued the defendant in state court for medical malpractice (the "state court action"). Mrs. Lo Nero is not a party to this action. In her state court action, Mrs. Lo Nero is seeking her medical expenses, among other things. The plan alleges in this action that it has paid at least some of the medical expenses that Mrs. Lo Nero is seeking to recover in the state court action. In Count I of the Complaint in this action, the plan seeks a declaratory judgment that it has a right of subrogation to recover what it has allegedly paid out on behalf of Mrs. Lo Nero. The remainder of the Complaint contains counts for the actual subrogation action. The only count at issue on this motion is Count I for declaratory judgment.

## DISCUSSION

The parties agree that the issue of plaintiffs' right of subrogation turns on two questions: 1) whether California Civil Code Section 3333.1, which prohibits subrogation for collateral source payments in medical malpractice actions, is preempted by the Employee Retirement Income Security act of 1974, as amended ("ERISA"), 29 U.S.C. 1001 et seq. and 2) whether the plan, at the relevant times, contained a right of subrogation at all.

## Preemption

Section 3333.1 provides in relevant part that

(b) No source of collateral benefits introduced [as evidence by a medical malpractice plaintiff] shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant.

Neither party disputes that the purpose and effect of this statute is to overturn the collateral source rule as it applies to medical malpractice actions and to prohibit subrogation in such actions. *Barme v. Wood*, 37 Cal.3d 174 (1984).

The ERISA statute is broadly preemptive of state laws. If a state law "relates to" employee welfare benefit plans, ERISA preempts it. 29 U.S.C. 1144(a); *Pilot Life Ins. Co. v. Dedeaux*, 107 S. Ct. 1549, 1553 (1987). Congress, however, did not intend the preemptive provisions of ERISA to divest the states of their power to regulate the insurance industry. "[F]ederal laws should not be construed to supersede state laws 'regulating the business of insurance.'" *Metropolitan Life Ins. Co. v. Massachusetts*, 471

U.S. 724, 736 (1984); 15 U.S.C. 1012(b). Congress expressly "saved" from ERISA preemption any state laws "which regulate insurance." 29 U.S.C. 1144(b) (the "savings clause"). Thus, if Section 3333.1 is a law regulating insurance, then it is not preempted by ERISA.

More precisely, if the a (sic) state law comes within the savings clause, it is not preempted as against insurance companies. Although Congress was careful to leave undisturbed by the ERISA legislation the reservation to the states of the task of insurance regulation, Congress was also careful to distinguish between insurance companies and ERISA plans. Congress recognized that the similarities between them would result in their being state laws that affect both. In order to keep legitimate state insurance regulations from encroaching on the exclusively federal domain of ERISA plan regulation, Congress qualified the savings clause with the "deemer clause" which provides that

[n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . .

29 U.S.C. 1144(b)(2)(B). Under the deemer clause, if a state law regulating the business of insurance has application on its face to ERISA plans as well, the state law is preempted insofar as it applies to the ERISA plans. *Metropolitan Life*, 471 U.S. at 747; *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1160-62 (9th Cir. 1986).



Thus, the preemption analysis in this case runs as follows. If Section 3333.1 relates to the plaintiff plans, it is preempted by the ERISA statute. If, however, Section 3333.1 is a state law regulating the business of insurance, it is "saved" from preemption and is fully operative. But, if the plaintiff plans are not insurance companies actually providing insurance contracts but rather must be "deemed" to be insurance companies by Section 3333.1 in order to come within that law's purview, then the plans are protected by the deemer clause from the operation of Section 3333.1. See *Pacyga*, 801 F.2d at 1159-62.

Defendant concedes that Section 3333.1 "relates to" the plans and is thus subject to preemption. Def. Opp. at 6. The next question is whether Section 3333.1 regulates the business of insurance. Defendant contends that it does. Plaintiff asserts that it does not. In *Pilot Life*, the Supreme Court stated that in order to regulate insurance, a statute "must not just have an impact on the insurance industry, but be directed to that industry." 96 L.Ed.2d at 96. It is true that Section 3333.1 on its face makes no mention of the insurance industry or any of its elements and that the law has application outside the insurance industry. On the other hand, Section 3333.1 is part of the Medical Injury Compensation Reform Act of 1975 (MICRA), the comprehensive effort of the California legislature to address what it saw as catastrophic skyrocketing in medical malpractice insurance premiums. The question of whether Section 3333.1 regulates insurance within the meaning of the ERISA savings clause is a close one.

Assuming, without deciding, in the defendant's favor that Section 3333.1 does regulate the insurance industry

and therefore does come within the protection of the ERISA savings clause, the question becomes whether ERISA's deemer clause protects the plaintiffs from the operation of Section 3333.1.

In attempting to understand the operation of the deemer clause, the *Metropolitan Life* and *Pacyga* cases are most instructive. In *Metropolitan Life*, the Court distinguished between insured and uninsured employee welfare benefits plans. "Plans may self-insure or they may purchase insurance for their participants. Plans that purchase insurance – so-called 'insured plans' – are directly affected by state laws that regulate the insurance industry." 471 U.S. at 732. The Court held that insured plans may be regulated by the states because the deemer clause need not come into play since insured plans do not have to be "deemed" anything in order to come under state insurance statutes. State insurance statutes simply end up indirectly regulating insured plans by regulating the insurance those plans purchase. Uninsured plans are different. They would not be indirectly regulated through insurance regulation and would have to be "deemed" part of the insurance industry in order to come within legitimate state insurance regulation. This is precisely what the deemer clause prohibits. "We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." *Id.* at 747; see also *Pacyga*, 801 F.2d at 1161.

The plan at issue here is a self-funded uninsured plan. Decl. of Morrissey in Support of Motion at 2-3. Although there is no evidence submitted by the plaintiffs to the effect that the plan carries no insurance at all or

that the plan provides no other services for which it is insured, these matters would still not take the plan out of the protection of the deemer clause. *Pacyga*, 801 F.2d at 1161-62; *Moore v. Provident Life and Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986).

In sum, Section 3333.1 is preempted by ERISA at least insofar as it would have applied to the plaintiffs here. The defendant cannot avail itself of the operation of Section 3333.1 to avoid plaintiffs' right to subrogate.

#### *Contractual Right of Subrogation*

Plaintiffs assert that if Section 3333.1 is preempted and therefore not an obstacle to subrogation, the plaintiffs have a contractual right of subrogation. Plaintiffs assert that the document setting forth the terms of the plan at issue is a valid and enforceable contract vesting in the plan itself rights of subrogation in two situations: 1) where a beneficiary recovers from a third party the value of benefits received from the plan, the plan may be reimbursed for those benefits, or 2) where a beneficiary does not, or cannot, assert its claim directly against a culpable third party, the plan may assert the substantive right of the beneficiary. Decl. of Morrissey in Support of Plaintiffs' Motion at 3.

In opposition, defendant points out that the plan's terms, as they existed in 1986, did not include the express right of subrogation. The plan today has an express subrogation term written into the plan in 1987. Decl. of

Morrissey at 3. In 1986, when the claimed right of subrogation at issue here would have arisen, the plan had no such express language.

Plaintiffs claim that language in the 1986 plan informing beneficiaries that they "will never receive more than 100% of the medical expenses incurred" was always interpreted by the plan's trustees to give the plan the rights of subrogation enumerated above and that the 1987 amendment to the plan making express these rights of subrogation were merely cosmetic and did not expand in any way the plan's subrogation rights. Decl. of Morrissey at 3. Defendant has submitted no evidence that such was not the case. Furthermore, it is well settled that the interpretation of a plan's provisions by its administrator will not be overturned absent arbitrary, capricious or legally erroneous conduct. *Nevill v. Shell Oil Co.*, 835 F.2d 209 (9th Cir. 1987). On the record before it, this Court rules that, Section 3333.1 being inapplicable to the parties herein, plaintiffs' (sic) possess the right to subrogate in the manner alleged in Count I of the Complaint in this action and therefore, Plaintiffs' Motion For Partial Summary Judgment as to Count I of the Complaint is hereby GRANTED.

SO ORDERED.

December 5, 1988  
San Francisco, California

/s/ Fern M. Smith  
FERN M. SMITH  
United States District Judge

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89-1048

No. 89-3226

Supreme Court, U.S.

FILED

FEB 2 1990

JOSEPH F. SPANIOL, JR.  
CLERK

In The  
Supreme Court of the United States

October Term, 1989

FMC CORPORATION,

*Petitioner,*

vs.

CYNTHIA ANN HOLLIDAY,

*Respondent.*

On Petition For Writ Of Certiorari To  
The United States Court Of Appeals  
For The Third Circuit

RESPONDENT'S BRIEF IN OPPOSITION  
TO PETITION FOR WRIT OF CERTIORARI

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**QUESTION PRESENTED**

Whether Section 514 (A)-(B) of the Employee Retirement Income Security Act of 1974 allows FMC Corporation's self-funded employee welfare benefit plan to avoid the effect of a Pennsylvania insurance statute abolishing the common law remedy of subrogation as to all entities which provide medical benefits to victims of motor vehicle accidents?

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## STATUTES INVOLVED

In addition to the statutes cited in the Petition for Writ of Certiorari, Section 1719 of the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 ("Motor Vehicle Law") provides

## § 1719. Coordination of benefits

(a) General rule. – Except for worker's compensation, a policy of insurance issued or delivered pursuant to this subchapter shall be primary. Any program, group contract or other arrangement for payment of benefits such as described in Section 1711 (relating to required benefits) 1712(1) and (2) (relating to availability of benefits) or 1715 (relating to availability of adequate limits) shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in Section 1711, 1712 or 1715 or workers' compensation.

(b) Definition. – As used in this section the term "program, group contract or other arrangement" includes, but is not limited to, benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

## STATEMENT OF THE CASE

As noted in FMC's statement of the facts, Cynthia Ann Holliday was entitled to medical benefits under the FMC Salaried Health Plan as of January 16, 1987. (App. 6A, 7A, 87A). Ms. Holliday was critically injured in an



automobile accident on that date, having suffered massive head injuries which have resulted in permanent impairment. Her medical expenses to date exceed \$178,000.00; the cost of future care is unknown. (App. 7A, 87A, 103A).<sup>1</sup>

The plan provides for coordination of benefits between first-party automobile coverage and the Plan as follows:

If you or a covered member of your family are eligible to receive benefits under another group medical plan, Health Maintenance Organization (HMO), government plan, or by "no-fault" automobile insurance which provides medical coverage, you may be eligible for benefits from those Plans and your FMC Plan. In the case of coverage by "no-fault" automobile insurance, FMC will pay covered expenses not paid for by no-fault insurance.

(App. 58A)

*No-Fault*

In some states with no-fault motor vehicle coverage, the carrier is the primary insurer in these jurisdictions. All medical expenses related to an accident must be submitted to the carrier and not the FMC Health Care Plan. Eligible expenses not paid for by no-fault insurance *will* be paid by the FMC Plan.

(App. 62A)

In accordance with the coordination of benefits and "no-fault" language of the Plan, the first \$10,000.00 in

<sup>1</sup> All citations labeled "App." are to the appendix filed to the brief of FMC which was docketed with the Third Circuit Court of Appeals.

medical bills were paid by the State Farm Mutual Automobile Insurance Company under a motor vehicle insurance policy owned by Mr. Holliday on the date of the accident. (App. 217A-219A). The Plan availed itself of the coordination of benefits and no-fault clauses,<sup>2</sup> commencing payment of medical bills only after State Farm's coverage was exhausted. (App. 220A-222A). Significantly, although Ms. Holliday's bills were well in excess of the \$100,000.00 threshold required for eligibility under the Pennsylvania Catastrophic Loss Trust Fund, Act of February 12, 1984, P.L. 26, 11-12, 75 Pa.C.S.A. Sections 1761-1769, (App. 223A-224A), and the Plan provides a one million dollar lifetime maximum per person (App. 15A), the Plan paid no expenses which qualified for Catastrophic Loss Trust Fund coverage.

FMC's Statement of Facts correctly recites a portion of the clause which purports to reserve subrogation rights to the Plan and further correctly notes that Mr. Holliday signed a third-party reimbursement form presented to him by an FMC representative under the authority of this provision. However, Mr. Holliday did so as a result of the final sentence of the subrogation clause contained in the Plan, which presents a Hobson's Choice to the beneficiary:

Unless you sign the Company's "third party reimbursement form", the claims administrator will not process any claim where there is possible liability on behalf of a third-party. (App. 63A).

<sup>2</sup> These clauses parrot Pennsylvania's Motor Vehicle Law in this regard. See *Statutes Involved, supra*.

Mr. Holliday then commenced the civil action as described in FMC's Statement of Facts. On September 3, 1987, President Judge Robert C. Earley of the Common Pleas Court of Indiana County, Pennsylvania, entered an Order granting the Petition of the tortfeasor to interplead his automobile liability insurance policy limit of \$100,000.00 and directed all potential plaintiffs to make claims against such funds. (App. 184A-192A). On May 2, 1989, an Order was entered approving a settlement by and between Ms. Holiday, three other individuals who made claim against the liability insurance proceeds in response to the interpleader, and the tortfeasor, the effect of which was to limit Cynthia Ann Holliday's recovery from the tortfeasor to \$49,875.50, plus accrued interest. (Petition for Writ of Certiorari, Page 5).

FMC notified Ms. Holliday of its intent to exercise subrogation rights with respect to the Indiana County action. Ms. Holliday refused to acknowledge the subrogation claim of FMC, citing Section 1720 of the Motor Vehicle Law. FMC then instituted a declaratory judgment action in the United States District Court for the Western District of Pennsylvania (Civil Action Number 88-1098), asserting a right of subrogation under the language of the Plan.

Upon cross-motions for summary judgment, the Honorable Alan N. Bloch granted Ms. Holliday's Motion for Summary Judgment and denied that of FMC.

The United States Court of Appeals for the Third Circuit affirmed the District Court in all respects. The Third Circuit, having conducted an exhaustive analysis of

the congressional intent underlying the various provisions of Section 514 of ERISA, held that Congress did not intend to preempt legitimate state regulations which do not operate to undermine the congressional purposes underlying the preemption clause. The Court found the anti-subrogation provision of the Motor Vehicle Law to be such a state regulation, and determined that Congress did not intend Section 514 of ERISA to preempt that Act of the Pennsylvania Legislature.

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#### SUMMARY OF ARGUMENT

For many reasons, the Court should not accept this case for review.

First, the Third Circuit Court of Appeals was correct that Pennsylvania's coordination of benefit laws should not be preempted merely because such laws have a tangential effect upon ERISA plans. In so holding, the Third Circuit is in concert with, and has followed, an equally cogent and well-reasoned opinion out of the Sixth Circuit. *Northern Group Services, Inc. vs Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987) cert. denied, 108 S.Ct. 1754 (1988), held that the proper inquiry under the deemer clause is whether the state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the preemption provision. The Third Circuit opinion conflicts only with an earlier result reached by the Ninth Circuit through a truncated analysis of the specific issue presented for decision. The other cases cited by FMC in its

attempt to construct a serious conflict are highly distinguishable on their essential facts, and lend nothing to an analysis of the importance (or lack thereof) of FMC's plea. The minor conflict which does exist is neither worthy of this Court's attention nor soluble by a review of this case.

Second, the Petition for Certiorari rests heavily on dicta found in *Metropolitan Life Insurance Co. vs. Massachusetts*, 471 U.S. 724 (1985). FMC asserts that this dicta categorically exempts from state automobile insurance regulation all self-funded employee benefit programs. Such flawed reasoning is rooted in no holding of this Court, ignores the approach uniformly applied by this Court in preemption cases, and fails when viewed in the context of the legislative history which underlies Section 514.

This Court has been repeatedly called upon or requested to review and decide questions of federal preemption under ERISA. This Court should not accept or open its door to automatic preemption of state law as the vehicle for resolution of every conceivable conflict arising between state laws and an ERISA plan. The maintenance of a federal system of government precludes adoption of so-called "bright line" tests which trample the will of Congress. The case at bar is inappropriate for Supreme Court review because the Third Circuit has already addressed the question presented in a manner consistent with this Court's earlier expressed views on the subject of state causes of action and ERISA plans.<sup>3</sup>

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<sup>3</sup> *Metropolitan Life Insurance Co. vs. Massachusetts*, 471 U.S. 724; 105 S.Ct. 2380; 85 L.Ed.2d 728 (1985); *Shaw vs. Delta Air*

(Continued on following page)

## REASONS FOR DENYING THE WRIT

### 1. No substantial conflict exists among the Circuit Courts of Appeals on the narrow issue before this Court.

FMC asserts the existence of "a substantial and direct conflict among the Courts of Appeals" as a justification for the issuance of a Writ of Certiorari by this Court. Such a Writ is "granted only when there are special and important reasons therefore." Rule 17.1, Rules of the Supreme Court of the United States. While a genuine conflict between the Courts of Appeals is concededly one of the considerations viewed by this Court, the mere existence of such a conflict in a given case does not control this Court's absolute discretion or justify an exercise of this Court's jurisdiction. Whether in matters of personal liberty or mere dollars, the sheer volume of conflict situations assures that far more of such cases must be rejected than can be heard. See *Brown Transport Corp. vs. Atcon, Inc.*, 439 U.S. 1014 (1978) (Dissenting opinion of Mr. Justice White). Ms. Holliday submits that certiorari should be granted only where the asserted conflict is genuine, widespread and pervasive, and is fundamental to the precise issue placed before the Court in the proffered case.

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(Continued from previous page)

*Lines Inc.*, 466 U.S. 85; 103 S.Ct. 2890; 77 L.Ed.2d 490 (1983); *Fort Halifax Packing Co. vs. Coyne*, 482 U.S. 1; 107 S.Ct. 2211; 96 L.Ed.2d 1 (1987); *Pilot Life Insurance Co. vs. Dedeaux*, 481 U.S. 41; 107 S.Ct. 1549; 95 L.Ed.2d 39 (1987); *Mackey vs. Lanier Collection Agency*, 486 U.S. \_\_\_, 108 S. Ct. 2182 (1988).



Perhaps in a tacit acknowledgment of this concept, FMC attempts to elevate its voice above the clamor by painting a portrait of pervasive conflict among the Circuit Courts of Appeals upon an issue defined with far greater breadth than may be justified by the facts of this dispute. This case neither demands nor requires the broadstroke ruling sought by FMC as to the tension between the preemption clauses of ERISA and every state insurance law which might, in any conceivable way, someday affect the legal rights of a self-funded employee welfare benefit plan such as FMC's.

Viewed in the light of the true question presented by this case, i.e., the effect of ERISA's preemption clause upon a state motor vehicle insurance law barring certain subrogation claims, the colossus of conflict erected by FMC crumbles. Several of the cases cited by FMC address the viability of state law remedies asserted by Plan participants against self-funded plans. See, e.g., *Powell vs. Chesapeake and Potomac Telephone Co.*, 780 F.2d 419 (4th Cir. 1985), cert. denied, 476 U.S. 1170 (1986); *Reilly vs. Blue Cross and Blue Shield United of Wisconsin*, 846 F.2d 416 (7th Cir.), cert. denied, 104 S.Ct. 145 (1988). This Court has left no room for doubt that ERISA proscribes such claims. *Shaw vs. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Pilot Life Insurance Co. vs. Dedeaux*, 481 U.S. 41, 95 L.Ed.2d 39, 107 S.Ct. 1549 (1987). Such cases are not pertinent to the analysis of this conflict because Holliday seeks no affirmative relief against a plan fiduciary and asserts no state remedy for benefits under the Plan.

A second cluster of cases cited by FMC involve holdings that state law cannot direct self-insured employee welfare benefit plans to provide certain types of plan

benefits. See, e.g., *Children's Hospital vs. Whitcomb*, 778 F.2d 239 (5th Cir. 1985); *Insurance Board of Bethlehem Steel Corp. vs. Muir*, 819 F.2d 408 (3rd Cir. 1987); *Liberty Mutual Insurance Group vs. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384, re-hearing denied, \_\_\_ F.2d \_\_\_ (6th Cir. 1989). Far from contributing to a splintering of opinion among the various Circuit Courts of Appeals on the subrogation issue, these decisions simply recognized dicta found in *Metropolitan Life Insurance Company vs. Commonwealth of Massachusetts, et al.*, 471 U.S. 724 (1985), wherein this Court determined the validity of such "mandated benefits" laws as applied to insured plans. These cases did *not* require consideration of the status of state laws affecting attempts by self-insured plans to assert subrogation against the tort recoveries of injured parties. To afford deference to dicta of this Court in a case involving the precise subject matter addressed by this Court in generating such dicta does not create a true conflict with a decision in a wholly different field of regulation.

Finally, FMC cites four decisions relating to the attempted enforcement of Plan subrogation rights in the face of state law which either provides no such right or affirmatively bars them from being asserted. A closer examination of these decisions reveals that the conflict is not so absolute as FMC would have this Court believe. *Baxter vs. Lynn*, 886 F.2d 182 (8th Cir. 1989), is a panel holding that "the (state's common) law of subrogation, while generally applicable to insurance contracts, is not specifically directed to the insurance industry." 886 F.2d at 186. The key factual distinction was the absence in *Baxter* of a state precept geared towards insurance regulation; the Court thus found a law of general application

not to have been saved from preemption by ERISA Section 514(b). The Court was not squarely faced with a state insurance regulation or the "deemer" question which FMC concedes to lie at the core of this appeal. The Panel's comments regarding the theoretical application of the "deemer" clause were mere dicta and are not necessarily indicative of the full Eighth Circuit Court of Appeal's position on the question presented to this Court today.

Two of the remaining decisions were born of exhaustive analyses of congressional intent, concluding that the "deemer" clause was not intended to preempt core provisions of state automobile insurance regulations, even as applied to self-funded plans. *Northern Group Services, Inc. et al. vs. Auto Owners Insurance Co., et al.*, 833 F.2d 85 (6th Cir. 1987), cert. denied 108 S.Ct. 1754 (1988); *FMC Corp. vs. Holliday*, 885 F.2d 79, re-hearing denied \_\_\_ F.2d \_\_\_ (3rd Cir. 1989). Although FMC's petition stresses the differences in intellectual approaches between the Sixth Circuit and the Third Circuit Courts of Appeals, the nature of the analysis utilized by each Court is in essence identical. Each Court scrutinized Congress' intent in enacting the relevant preemption provisions of ERISA, and concluded that, as to the *particular* type of state automobile insurance regulation before it, Congress did not intend federal preemption to occur because the state provision at issue was not a surreptitious attempt to supplant federal pension regulation with state controls. See *Northern Group Services*, 833 F.2d at 93; *Holliday*, 885 F.2d at 87-90. FMC's complaint that the *Northern Group Services* and *Holliday* Courts created "two different, but equally amorphous, tests" dissipates in the face of the language of the opinions. The *Northern Group Services* Court determined that,

"where there is no demonstrated interest in national uniformity and preemption of state law which substantially disrupt a state regulatory scheme generally applicable to both insured and self-insured ERISA plans, as well as to insurers generally, the deemer clause does not bar regulation." 833 F.2d at 95.

The *Holliday* Court found that,

"self-insured plans would merely be considered on a case by case basis as to whether the state regulation involved affects a central concern of ERISA. *Northern Group Services*, 833 F.2d at 94-95. In light of the available interpretive materials, the proper inquiry under the deemer clause is whether the state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the preemption provision. The Court, reviewing a state insurance law, should inquire whether that law conflicts with any substitute mandate in ERISA." 885 F.2d at 89-90.

It is impossible to identify any conceptual difference between an "interest in federal uniformity" and a "central concern of ERISA"; these are the same thought variously expressed. It is difficult to fathom any real difference in the aims or approaches of the two Courts, as each is concerned with identification of the congressional intent underlying ERISA. "The purpose of Congress is the ultimate touchstone. (Citations)". *Pilot Life Insurance Company vs. Dedeaux*, 107 S.Ct. at 1552.

Nor does FMC's concern over future litigation justify this Court's attention to the Third Circuit opinion in this case. This Court has previously recognized that, at least in the context of ERISA's civil enforcement provisions, federal courts would have to develop common law to

define rights and liabilities in an ERISA world. *Pilot Life Insurance Company vs. Dedeaux*, 107 S.Ct. at 1557-1558. The judicial development of ERISA rules born of the efforts of federal courts to identify the congressional intent and federal interests underlying a statutory scheme, is to be anticipated given the language of this statute. See *Metropolitan Life*, 471 U.S. at 724.

Ms. Holliday recognizes that the decision of the Ninth Circuit panel in *United Food and Commercial Workers vs. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) is in conflict with the holdings of the *Northern Group Services* and *Holliday Courts*. A brief perusal of its opinion demonstrates that the *Pacyga* Court, failing to concern itself with congressional intent as this Court and others have done, chose the path of blind application of certain dicta offered in a different context by this Court in *Metropolitan Life Insurance Co. vs. Massachusetts*, *op. cit.*, and dismissed out of hand any suggestion that the Arizona anti-subrogation law might survive ERISA's preemption provisions. Thus, on the real subject matter of the current controversy, this Court must consider whether the existence of a conflict between two Circuit Courts which have taken parallel paths to the same conclusions and one which has "short-cut" in the opposite direction justifies the extraordinary relief of certiorari.

The magnitude of this conflict dims as the facts of each cited case are illuminated in the background. Total uniformity, while a classroom ideal, is not a species found in the living law. This Court, as it should, has always devoted its energies to serious conflicts. The slight deviation by the Ninth Circuit in *Pacyga* does not warrant the

application of this Court's resources to the Third Circuit's mainstream opinion.

**2. The Third Circuit decision is not in conflict with any holding of this Court.**

FMC asserts that the Third Circuit has ignored binding precedent created in *Metropolitan Life Insurance Co. vs. Massachusetts*, 471 U.S. 724 (1985). In so doing, FMC incorrectly analyzes the scope of the *Metropolitan Life* holding.

*Metropolitan Life* resulted from a state court action seeking insurance company compliance with a Massachusetts statute requiring any insurance policies sold within the state to contain certain mental health care coverages. The carriers resisted, arguing that ERISA Section 514 preempted the Massachusetts "mandated benefits" law. The result of this Court's painstaking analysis of Section 514(b) was a holding that the Massachusetts statute was not preempted as to the parties litigating the issue.

Critically, none of the parties to *Metropolitan Life* were a self-funded employee welfare benefit plan. This Court took great care to note that Massachusetts removed the question of mandated benefits laws as applied directly to self-funded plans before that matter could reach the Court. 471 U.S. at 734, n.14. This Court was neither required nor requested to encompass self-funded plans within its holding in *Metropolitan Life*. The language relating to self-funded plans, upon which FMC relies to establish a conflict between this Court and the Third Circuit



Court of Appeals, is dicta. Dicta is neither binding precedent nor part of any holding of this Court. *McDaniel vs. Sanchez*, 452 U.S. 130 (1981).

Moreover, the *Metropolitan Life* dicta must be viewed in the context of the peculiar type of state law then before the Court, i.e. a mandated benefits law. Such dicta has persuasive value, only insofar as it indicates that *mandated benefits laws* should not be applied to self-funded plans. The Pennsylvania anti-subrogation statute, while an insurance statute (as determined by the District Court and the Third Circuit, and as argued by FMC), is of a different character from mandated benefits laws; the former restricts plan efforts to assert a traditional state law remedy, while the latter dictates what coverages a plan administrator must offer. The need to ferret out congressional intent as to the former type of legislation is obvious, as this Court has recognized that preemption is not automatic. *Fort Halifax Packing Co., Inc. vs. Coyne*, 482 U.S. 1 (1987). The Third Circuit's conduct in *Holliday*, far from contradicting this Court's holdings, marches in step with this Court's approach to ERISA preemption as to the type of state enactment to be addressed in this case.

**3. Acceptance of jurisdiction over this case will not substantially reduce litigation over ERISA preemption.**

FMC asserts a belief that, if this Court accepts jurisdiction and reverses the judgement of the Third Circuit Court of Appeals, endless litigation and diversity of national impact will be avoided. FMC thus proposes that Congress intended to trample upon state regulatory

authority with no discrimination whatsoever and without respect to the maintenance of a federal system of government.

"ERISA preemption analysis must be guided by respect for the separate spheres of governmental authority presented in our federal system".

*Fort Halifax Packing Company, Inc. vs. Coyne*, 482 U.S. 1, \_\_\_, 107 S.Ct. 2211, 2221 (1987), citing *Alessi vs. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981). Such sensitivity to the continued existence of a federal system renders inevitable a certain degree of litigation to balance the ongoing tension between federal and state interests. This Court has never suggested that ERISA preemption is absolute; rather, it has continuously examined congressional attitudes and found that Congress recognizes the ongoing right of the states to regulate traditional areas of concern, even where such regulation impacts upon employee welfare benefit plans. See, e.g., *Metropolitan Life, op. cit.*; *Fort Halifax Packing Company*, 482 U.S. at \_\_\_, 107 S.Ct. at 2215; *Mackey vs. Lanier Collection Agency*, 486 U.S. \_\_\_, 108 S.Ct. 2182 (1988). Avoidance of adjudication of the bounds between federal and state interplay is simply not a justification for an exercise of this Court's jurisdiction in view of the inherency of this process to our federal system.

The *Mackey* decision perhaps best illustrates this idea. This Court refused, in *Mackey*, to hold that Georgia's scheme for enforcement of civil judgements could not apply to an ERISA plan. In so doing, this Court found Congress to have intended that ERISA plans should be amenable to suit upon various state causes of action.

*Mackey*, 108 S.Ct. at 2186-2187. In the context of widely varying state laws and causes of action, this finding belies FMC's asserted mandate of absolute uniformity in all matters touching upon all self-funded plans. *Mackey* strongly suggests that Pennsylvania's Section 1720 was intended by Congress to survive Section 514(a), since it not only falls into a class of regulations specifically designated by Congress as ERISA "survivors" (i.e., insurance laws), but also addresses the existence (or non-existence) of a traditional state law claim (i.e., subrogation in conjunction with common law tort actions). Review of the Third Circuit's approval of this statute will, therefore, add nothing to the debate over the scope of ERISA preemption, as the Third Circuit dovetailed with this Court and Congress in finding this statute to be outside the scope of the pretextual sorts of enactments which Congress sought to prevent through the enactment of Section 514. See 885 F.2d at 87-90.

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#### CONCLUSION AND RELIEF

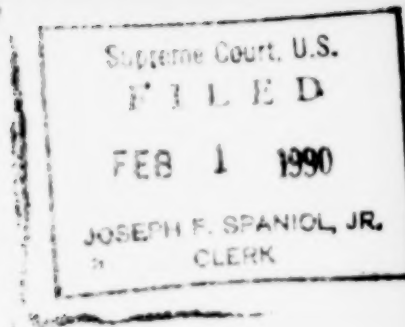
This case is not appropriate for Supreme Court review and, therefore, the subject Petition for Writ of Certiorari should be denied.

January 31, 1990

Respectfully submitted,

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No. 89-1048

IN THE  
SUPREME COURT OF THE UNITED STATES  
October Term, 1989

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FMC CORPORATION,

Petitioner,

v.

CYNTHIA ANN HOLLIDAY,

Respondent.

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PETITION FOR A WRIT  
OF CERTIORARI TO THE UNITED STATES  
COURT OF APPEALS FOR THE THIRD CIRCUIT

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BRIEF IN OPPOSITION TO THE PETITION  
FOR WRIT OF CERTIORARI

---

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QUESTIONS PRESENTED

1. Should this Court grant certiorari on an ERISA preemption claim where the ERISA plan already took advantage of certain provisions of the state law and only seeks preemption of certain other portions?

2. Should this Court grant certiorari and review a Pennsylvania motor vehicle insurance statute where there is no conflict among the Courts of Appeals on the issue of ERISA preemption as to such statutes and where this Court has previously declined to review the same result?

3. Should this Court review the Third Circuit decision concerning the meaning of ERISA's deemer clause when the Pennsylvania statute does not relate to ERISA plans to such an extent as to come within ERISA's initial preemption clause?

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STATEMENT OF THE INTEREST OF  
AMICUS CURIAE PENNSYLVANIA  
TRIAL LAWYERS ASSOCIATION

Pursuant to Rule 37.2 of the Rules of the Supreme Court of the United States, the Pennsylvania Trial Lawyers Association files this Brief as Amicus Curiae supporting the position of Respondent Cynthia Ann Holliday. Signed consents permitting the filing of this Brief, from Counsel for Petitioner FMC Corporation and from Attorney Thomas G. Johnson representing Respondent Cynthia Ann Holliday, have been filed with the Clerk of this Honorable Court. The Pennsylvania Trial Lawyers Association is a private non-profit association with a membership of nearly 4,500 trial attorneys in the Commonwealth of Pennsylvania, predominately representing

injured parties in their attempt to seek redress for their injuries in the Courts. The issue of subrogation in Pennsylvania automobile cases has a significant impact on the interests of injured parties and on the practice of law in Pennsylvania. Any determination, therefore, by this Honorable Court of the issues in the case at bar will directly affect the members of the Pennsylvania Trial Lawyers Association and the interests of their clients.

This Brief is filed timely pursuant to the schedule established by the Rules of this Honorable Court for the filing of Briefs in Opposition to a Petition for a Writ of Certiorari.

### STATUTES INVOLVED

In addition to the statutes identified by Petitioner, this case involves Section 1719 of the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 (the "Financial Responsibility Law") which provides:

- (a) General rule. - Except for workers' compensation, a policy of insurance issued or delivered pursuant to this subchapter shall be primary. Any program, group contract or other arrangement for payment of benefits such as described in section 1711 (relating to required benefits) 1712(1) and (2) (relating to availability of benefits) or 1715 (relating to availability of adequate limits) shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in section



1711, 1712 or 1715 or workers'  
compensation.

75 Pa. Cons. Stat. Ann. §1719(a)  
(Purdon 1984).

SUMMARY OF REASONS

The Petitioner seeks to have this Court determine that Section 514(a) of the Employee Retirement Income Security Act of 1974 preempts the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984. If the state law were preempted, it would be preempted for all purposes. Both the District Court and the Court of Appeals, however, found that the Petitioner herein availed itself of the benefits of the Financial Responsibility Law to reduce the amount that it would have been required to pay on behalf of the Respondent. The decisions of this Court do not allow an ERISA plan to pick and choose those parts of a state law which benefit the

plan but "preempt" those parts that the plan does not find desirable. Consequently, certiorari should not be granted herein where Petitioner has already taken advantage of the law it now seeks to have preempted.

The Petitioner incorrectly argues that the Court of Appeals for the Third Circuit did not follow this Honorable Court's decision in Metropolitan Life Insurance Company v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed. 2d 728 (1985).

The decision of the Court of Appeals in this matter specifically cited Metropolitan Life and the Court of Appeals for the Third Circuit has applied the dictates of Metropolitan Life in prior decisions. See Insurance Board of Bethlehem Steel Corp. v.

Muir, 819 F.2d 408 (1987). The Court of Appeals simply held that Metropolitan Life was not controlling in this case.

There is not a substantial and direct conflict among the Courts of Appeals on this issue. The decisions cited by Petitioner to support its argument of conflict involve different issues than the question of preemption of a state automobile no-fault insurance statute. It is noteworthy that this alleged "conflict" has existed for quite some time and that this Honorable Court has on at least three prior occasions refused writs for certiorari in the same cases used by

Petitioner to support its present argument about this "conflict".<sup>1</sup> The Petitioner presents no reasons as to why this Court should now grants its petition having thrice refused this issue.

This case does not have national significance such as would justify consuming the judicial resources of this Honorable Court. In addition, this amicus curiae

1. Powell v. Chesapeake and Potomac Telephone Co. of Virginia, 780 F.2d 419 (4th Cir. 1985), cert. denied, 476 U.S. 1170 (1986); Reilly v. Blue Cross and Blue Shield United of Wisconsin, 846 F.2d 416 (7th Cir. 1988), cert. denied, 104 S.Ct. 145 (1988); Northern Group Services, Inc. v. Auto Owners Insurance Co., 833 F.2d 85 (6th Cir. 1987), cert. denied, 108 S.Ct. 1754 (1988).

presents an alternative argument that the statute herein does not "relate to" ERISA such that it should be preempted.



REASONS FOR DENYING THE PETITION FOR  
WRIT OF CERTIORARI

- I. THE PETITIONER HAVING AVAILED ITSELF OF THE BENEFITS OF THE PENNSYLVANIA MOTOR VEHICLE FINANCIAL RESPONSIBILITY LAW CANNOT NOW ARGUE THAT THE LAW IS PREEMPTED.

It is uncontested that the FMC Corporation took advantage of those provisions of the Pennsylvania Motor Vehicle Financial Responsibility Law that were helpful to it. At a minimum, this included having the applicable automobile insurance carrier pay its full Ten Thousand (\$10,000.00) Dollars of medical benefits coverage before FMC paid any benefits on behalf of the Respondent. (Petition for Writ of Certiorari at page A4.) The plan of the FMC Corporation specifically incorporated into its terms "no-fault"

automobile insurance plans such as the Pennsylvania law in question. (See Petition at page A3.) Having now availed itself of those provisions of the Financial Responsibility Law which it considered beneficial to itself, the Petitioner now suggests that federal law should preempt those portions of the Financial Responsibility Law which it does not find beneficial, in particular Section 1720. It is important to note that the FMC plan in this case was included in section 1720 of the Financial Responsibility Law by its identification in the coordination of benefits provision of section 1719.

The Petitioner misunderstands the scope of the preemption clause in Section 514(a) of

ERISA. The Petitioner cannot "pick and choose" those portions of a state law which are of benefit to it and seek to "preempt" other portions. If a law is preempted, it does not matter that portions of it would be beneficial to the Petitioner or consistent with ERISA requirements. Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 2389, 85 L.Ed. 2d 728 (1985); Mackey v. Lanier Collections Agency, 486 U.S. 825, 108 F.Ct. 2182, 2185, 100 L.Ed. 2d 836 (1988).

FMC took advantage of Section 1719 of the Financial Responsibility Law pertaining to the coordination of benefits between automobile insurance and the plan and is therefore estopped from arguing that other portions of

the law should be preempted by ERISA. No explanation has ever been offered by FMC at any time during the pendency of this matter as to why or how certain parts of the Financial Responsibility Law would be preempted but not other parts. Since FMC by its conduct has relied on and used the Financial Responsibility Law to its own advantage, it is estopped from arguing that the law is preempted by ERISA.

II. THE COURT OF APPEALS DID NOT DISREGARD, AND ITS DECISION IS NOT CONTRARY TO, THIS COURT'S DECISION IN METROPOLITAN LIFE INSURANCE CO. V. MASSACHUSETTS.

The Petitioner argues in its Petition that the Court of Appeals for the Third Circuit ignored this Court's decision in

Metropolitan Life when it analyzed the congressional intent behind the ERISA preemption, savings and deemer clauses. This is simply incorrect.

This Court has repeatedly held that it is necessary to analyze the purpose behind the preemption clause to determine the intent of Congress in order to decide if a state law is preempted by ERISA. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 95, 103 S.Ct. 2890, 77 L.Ed. 2d 490 (1983); Metropolitan Life, 105 S.Ct. at 2389; Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 51 - 52, 107 S.Ct. 1549, 95 L.Ed. 2d 39 (1987).

While the preemption clause of ERISA is very broad, this Court has determined that "we must also presume that Congress did not intend

to pre-empt areas of traditional state regulation." Metropolitan Life, 105 S.Ct. at 2389. Certainly state automobile insurance laws are familiar examples of an area of traditional state regulation. See Metropolitan Life, 105 S.Ct. at 2383.

Congress intended that the preemption clause of ERISA would not interfere with the ability of the states to regulate their traditional areas of responsibility.

ERISA preemption analysis "must be guided by respect for the separate spheres of governmental authority preserved in our federalist system".

Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 107 S.Ct. 2211, 2221, 96 L.Ed. 2d 1 (1987), citing Alessi v. Raybestos-Manhattan,



Inc., 451 U.S. 504, 522, 101 S.Ct. 1895, 1905 (1981). This is exactly the analysis which the Court of Appeals undertook in this matter. This analysis was in keeping with the clear mandate of the decisions of this Court.

The decision by the Court of Appeals is in accord with the reasoning of Metropolitan Life.

III. THERE IS NO SUBSTANTIAL AND DIRECT CONFLICT AMONG THE COURTS OF APPEALS THAT A DECISION IN THIS CASE WILL RESOLVE.

The Petitioner argues that the Court of Appeals for the Third and Sixth Circuits are in conflict on this preemption issue with the Courts of the Fourth, Fifth, Seventh, Eighth and Ninth Circuits which Petitioner states "have followed Metropolitan Life". There is

no such conflict.

As noted above, the Court of Appeals in the case at bar did follow the required analysis set forth by this Court in Metropolitan Life. The particular issue in Metropolitan Life involved whether a state law could mandate that a self-funded ERISA plan must provide certain benefits. Both the Third and the Sixth Circuits have held in accord with this Court's decision in Metropolitan Life that such state laws are preempted by ERISA. Insurance Board of Bethlehem Steel Corporation v. Muir, 819 F. 2d 408 (3d Cir. 1987); Liberty Mutual Insurance Group v. Iron Workers Health Fund of Eastern Michigan, 879 F.2d 1384 (6th Cir. 1989). In cases involving state laws mandating the

provision of certain benefits, there is an easily applied "bright-line" test of whether the ERISA plan is self-funded as opposed to fully insured. Such a simplistic test does not work in analyzing the preemption issue as it involves a state motor vehicle "no-fault" statute which clearly encompasses an area of traditional state regulation. The analysis provided by the Court of Appeals for the Third Circuit in this case was totally in line with the dictates of this Court.

The decisions cited by the Petitioner from the other Courts of Appeals are not in direct conflict with the decision at bar. Both Children's Hospital v. Whitcomb, 778 F.2d 239, (5th Cir. 1985) and Reilly v. Blue Cross and Blue Shield United of Wisconsin, 846 F.2d

416 (7th Cir. 1988), cert. denied, 104 S.Ct. 145 (1988), dealt with state requirements that a plan provide certain benefits or state law remedies to force a plan to provide certain benefits. These decisions are directly determined by Metropolitan Life. Both Baxter v. Lynn, 886 F.2d 182 (8th Cir. 1989) and United Food & Commercial Workers v. Pacyga, 801 F.2d 1157 (9th Cir. 1986) dealt with state common law prohibitions against subrogation. Neither involved a comprehensive state motor vehicle insurance statute where the analysis used by the Court of Appeals herein was necessary given the traditional state interest in automobile insurance. In Powell v. Chesapeake & Potomac Telephone Co. of Virginia, 780 F.2d 419 (4th Cir. 1985), cert.

denied, 476 U.S. 1170 (1986), the issue was the application of the state insurance trade practices law to the plan, which would have required that the state "deem" the plan to be an insurance company.

Only Northern Group Services, Inc. v. Auto Owners Insurance Co., 833 F.2d 85 (6th Cir. 1987), cert. denied, 108 S.Ct. 1754 (1988), involved the same issue as the case at bar. Petitioner concedes that both Courts of Appeals applied the same reasoning and reached the same conclusion. This Court refused to review the Northern Group Services decision.

It is noteworthy that even if one were to use the broad generalizations that Petitioner uses in attempting to argue that there is a conflict, the cases cited by Petitioner

clearly establish that this Court has on at least three prior occasions refused to resolve the alleged conflict. Powell, cert. denied, 476 U.S. 1170 (1986); Reilly, cert. denied, 104 S.Ct. 145 (1988); Northern Group Services, cert. denied, 108 S. Ct. 1754 (1988).

#### IV. THERE IS NO FEDERAL INTEREST IN PREEMPTING THE PENNSYLVANIA MOTOR VEHICLE FINANCIAL RESPONSIBILITY LAW.

Both the case at bar and the Northern Group Services case involved state no-fault automobile insurance laws and a state's uniform scheme of coordination of benefits. In neither case is there a discernable federal interest and the holdings are quite limited to the facts set forth in those cases.



The issue involved in this case is a preemption of the Pennsylvania Financial Responsibility Law and not just the section that the Petitioner does not find beneficial to its interests. If the Financial Responsibility Law were preempted by ERISA, the Petitioner is under the incorrect assumption that its plan would then become the law of Pennsylvania for all of its beneficiaries. It is particularly noteworthy that the subrogation clause of the FMC Salary Health Plan as spelled out at page A4 of the Petition for Writ of Certiorari specifically provides that a beneficiary under the plan bringing a liability claim against any third party must claim benefits paid pursuant to the FMC plan and must reimburse the plan for

all benefits provided. The enforcement of such plan provisions would fly directly in the face of the Pennsylvania "no-fault" motor vehicle insurance system and could change the rules of state pleading and procedure in third-party tort liability cases where a plan beneficiary was involved. No-fault motor vehicle insurance laws traditionally restrict the ability of injured parties to collect certain benefits in third party tort suits.

The provisions of the FMC plan would not be substituted for the Financial Responsibility Law but rather this Court or another federal court would have to establish Federal "common law" as to automobile liability claims and coordination of benefits provisions. It certainly was never the

intention of Congress that the federal courts would adopt a national uniform system of automobile insurance claims and procedure pursuant to ERISA. Yet this is what would occur if the simplistic test advocated by the Petitioner were to be adopted by this Court. The decision of the Court of Appeals applying the analysis mandated by this Court was the correct decision in this case. The Petition for Certiorari should be denied by this Honorable Court.

V. THE PENNSYLVANIA FINANCIAL RESPONSIBILITY LAW DOES NOT "RELATE TO" THIS PLAN SUCH THAT IT WOULD BE PREEMPTED BY ERISA.

Although the Court of Appeals for the Third Circuit decided that the Financial Responsibility Law does "relate to" employee

benefit plans, 29 U.S.C. §1144(a), this amicus curiae argued in that Court that the Financial Responsibility Law does not come within the scope of the ERISA preemption in the first place.

It is firmly established that not all state laws with an impact on ERISA plans are preempted. This Court determined in Mackey v. Lanier Collections Agency that ERISA did not supersede the Georgia garnishment law and as part of its discussion listed numerous state laws which "although obviously affecting and involving ERISA plans and their trustees, are not pre-empted by ERISA §514(a)." 108 S.Ct. 2187. In Shaw v. Delta Airlines, Inc., 463 U.S. 85, 87, 103 S.Ct. 2890, 2901, 77 L. Ed. 2d 490 (1983), this Court held that "some

state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant the finding that the law 'relates to' the plan".

The Pennsylvania Financial Responsibility Law is not aimed at ERISA plans nor does it deal with the subjects regulated by ERISA. The Pennsylvania Law is concerned with no-fault automobile insurance, not employee benefit plans. It does not require employee benefit plans to provide coverage for automobile accidents or even to provide any health benefits coverage at all. The Financial Responsibility Law does not materially "relate to" or "proport to regulate" ERISA plans and therefore is not

preempted.

### CONCLUSION

The analysis by the Court of Appeals was sound and as directed by this Court's prior decisions. The Petition for Writ of Certiorari should be denied by this Honorable Court.

Respectfully Submitted,  
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Supreme Court, U.S.

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IN THE  
**Supreme Court of the United States**  
OCTOBER TERM, 1989

FMC CORPORATION  
*Petitioner,*

v.

CYNTHIA ANN HOLLIDAY,  
*Respondent.*

On Petition for a Writ of Certiorari to the  
United States Court of Appeals  
for the Third Circuit

BRIEF AMICUS CURIAE OF SELF-INSURANCE  
INSTITUTE OF AMERICA, INC. (SIIA)  
IN SUPPORT OF  
PETITION FOR WRIT OF CERTIORARI

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IN THE  
**Supreme Court of the United States**  
OCTOBER TERM, 1989

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No. 89-1048

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On Petition for a Writ of Certiorari to the  
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BRIEF AMICUS CURIAE OF SELF-INSURANCE  
INSTITUTE OF AMERICA, INC. (SIIA)  
IN SUPPORT OF  
PETITION FOR WRIT OF CERTIORARI

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The Self-Insurance Institute of America, Inc. (SIIA) hereby submits this brief in support of the petition filed in No. 89-1048 for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit entered on September 11, 1989.

SIIA has obtained the written consent of both FMC Corporation and Cynthia Ann Holliday to the filing of a brief *amicus curiae* in support of the petition for certiorari.<sup>1</sup>

### INTEREST OF THE AMICUS

SIIA is a non-profit corporation composed of over 700 members dedicated to the advancement and protection of the self-insurance industry. SIIA's membership includes users of self-insurance such as employer plan sponsors, as well as service providers such as third-party administrators, reinsurance companies, and other entities engaged in the self-insurance business. SIIA is the only association in the U.S. which represents firms, professionals, and organizations which participate in the broad spectrum of self-insurance, including self-insured group health plans.

Through SIIA, its members coordinate their views and provide practical information and recommendations to government and the public on how the self-insurance system functions, and on the impact of government regulations and interpretations under the Employee Retirement Income Security Act of 1974 (ERISA) concerning self-insured health plans and plan participants. This includes rendering assistance to courts in their deliberations on significant self-insured health plan issues of broad concern to members.

SIIA has an interest in the ERISA preemption issue presented by the petition for three reasons. First, member companies which sponsor self-insured benefit plans face a significant potential monetary loss under

<sup>1</sup> Original consent letters from both FMC Corporation and Cynthia Ann Holliday have been lodged with the Court.

the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 (75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1984)) or similar statutes in other states because, since the passage of ERISA in 1974, such plans have contained subrogation clauses allowing recovery of medical expenses paid by such plans for injuries sustained through the negligence of third parties. Second, because many SIIA employer members operate on a multistate basis, they are legitimately concerned that any erosion of ERISA's preemption provisions will subject self-insured health plans to burdensome and costly state regulation which will severely hamper their efforts to maintain uniform and equitable benefits for covered employees. Third, the Third Circuit's decision<sup>2</sup> creates significant administrative problems for thousands of contract administrators who provide services to self-insured health plans.

Accordingly, SIIA files this *amicus curiae* brief in support of the petition for certiorari.

### REASONS FOR GRANTING THE WRIT

The importance of the Third Circuit's decision in this case and the need for prompt review by this Court cannot be overstated.<sup>3</sup> As the petition makes clear, that decision created a square conflict with other circuits which have followed this Court's holding in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), that Section 514 of ERISA preempts state regulation of self-insured

<sup>2</sup> *FMC Corp. v. Holliday*, 885 F.2d 79, *reh'g denied*, — F.2d — (3d Cir. 1989).

<sup>3</sup> The principal issue in this case is whether through its "deemer clause" ERISA preempts application to self-funded

health plans.<sup>4</sup> More specifically, the Third Circuit's decision, as well as a decision by the Sixth Circuit in *Northern Group Services v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 108 S.Ct. 1754 (1988), that ERISA does not preempt a state anti-subrogation insurance statute as applied to self-insured plans, are in direct conflict with the Ninth Circuit's decision in *United Food & Commercial Workers v. Pacyga*, *supra*, 801 F.2d 1157 (9th Cir. 1986).

This conflict has created widespread uncertainty on an important question of federal law directly affecting thousands of self-funded health plans, administrators who provide services to such plans, and millions of plan beneficiaries. It has also heightened the potential of increased litigation involving and affecting self-insured health plans, a threat which may

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health plans of the anti-subrogation provision in Pennsylvania's Motor Vehicle Financial Responsibility Law of 1984. The Third Circuit held that ERISA's express preemption provisions did not preclude application of the Pennsylvania statute to self-funded health plans.

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<sup>4</sup> See *Baxter v. Lynn*, 886 F.2d 182, *reh'g denied*, — F.2d — (8th Cir. 1989); *Reilly v. Blue Cross and Blue Shield of Wisconsin*, 846 F.2d 416 (7th Cir. 1988), *cert. denied*, 109 S.Ct. 145 (1988); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986); *Powell v. Chesapeake & Potomac Tele. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986); *Children's Hosp. v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985). In *Insurance Board of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987), the Third Circuit itself has also held that ERISA preempts state insurance law as applied to self-insured health plans.

undermine the continued growth of such plans as an alternative to purchased insurance for delivering health benefits to employees.

**A. THE THIRD CIRCUIT FAILED TO RECOGNIZE THE DISTINCTION BETWEEN INSURANCE AND SELF-INSURANCE AND HAS THEREBY CREATED CONFUSION ON AN IMPORTANT QUESTION OF LAW.**

In holding that a state insurance law applies to a self-insured health plan, the Third Circuit ignored ERISA's express statutory language and this Court's holding in *Metropolitan Life*, *supra*, that such benefit plans are exempted from state regulation. As this Court was at pains to point out in *Metropolitan Life*, "uninsured" employee benefits are not open to even "indirect regulation" under state law. 471 U.S. at 746-47.

The Third Circuit not only overlooked the longstanding distinction between insurance and self-insurance recognized in *Metropolitan Life*, but also misinterpreted ERISA's legislative history relating to preemption.<sup>5</sup> Thus, the Third Circuit's decision has

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<sup>5</sup> ERISA's legislative history confirms that, subject to certain narrow exceptions set forth in the statute, Congress intended to preempt all state law relating to employee welfare benefit plans. As explained by Rep. Dent, former Chairman of the Subcommittee on Labor of the House Labor and Education Committee:

I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority of the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by



created confusion among firms who sponsor and administer self-funded health plans and who have acted in reliance on ERISA's broad preemption provisions, and this Court's previous interpretations.<sup>6</sup> In addition, the Third Circuit decision has created widespread uncertainty over the extent to which state insurance laws and regulations apply to self-funded health plans that operate currently within a federal regulatory framework which allows such plans the flexibility to incorporate a variety of plan design features, including subrogation clauses, within the plans.

There can be no serious dispute about the historical distinction between insurance and self-insurance upon which employers who self-insure have always relied.<sup>7</sup> It is a longstanding practice that self-insured

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eliminating the threat of conflicting and inconsistent State and local regulation.

120 Cong. Rec. 29197 (1974). The legislative history clearly demonstrates that Congress, in enacting ERISA, intended to replace the conflicting system of state and local regulation of employee benefit plans with a "uniform source of law" for evaluating the conduct of plan administrators. Introductory Statement of Sen. Javits on S. 1557, reprinted in 1 *Legislative History of ERISA of 1974* at 273, 279 (1973); accord 120 Cong. Rec. 29933 (1974) (statement of Sen. Williams); *id.* at 29197 (statement of Rep. Dent).

<sup>6</sup> *E.g.*, *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

<sup>7</sup> The concept of self-insurance can be traced back to the middle ages when the sea-faring Phoenicians assumed the total risk of loss of destruction of their maritime fleets on voyages around the world. Indeed, as far back as the thirteenth century, merchant guides provided members with "insurance" protection against fire, shipwreck, flood, disability

risks, including the medical expenses of employees, can be financed by employers from their own current revenues. Even prior to ERISA, state courts understood that an employer who self-insures health benefits is not in the "insurance business." *Farmer v. Monsanto Co.*, 517 S.W.2d (Mo. 1974). ERISA codified and expanded this well established distinction in 1974 when it adopted a broad Section 514 preemption provision, including a "deemer" clause which expressly removed *uninsured* benefit plans from the scope of the ERISA insurance savings clause.

In concluding that ERISA's "deemer" provision does not insulate self-funded health plans from state regulation, the Third Circuit fashioned a new judicial standard. Thus, under the Third Circuit's approach, for the first time the "deemer" clause was held not applicable to self-funded health plans in cases where a state anti-subrogation law "affects a central concern of ERISA." *FMC Corp. v. Holliday*, *supra*, 885 F.2d at 89. The Third Circuit surprisingly concluded that, notwithstanding the Pennsylvania Motor Vehicle Law's direct interference with a basic plan design feature integral to a health plan, namely a subrogation clause, the Pennsylvania statute did not affect any "core" ERISA concerns. This novel and illogical interpretation involving application of a judicially contrived standard to ERISA's "deemer" clause raises a significant question of law to be addressed by this Court.

The dilemma now facing those who self-insure health benefits simply stated is: "Do we rely on the

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and other misfortunes while those not protected by the guild assumed the risk of their own losses. W. Durant, *Story of Civilization*, Vol. IV (1950).

express ERISA preemption language which states that no "employee benefit plan . . . shall be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . , 29 U.S.C. § 1144(b) (2) (B), or do we expend the time and money necessary to amend our self-insured health plans to comply with a multiplicity of state insurance laws?" Or, more troublesome, employers who self-insure ask: "Do we heed the Third Circuit in *FMC Corp.* and terminate our self-insured health plans (or fail to start new ones) or should we instead convert to a more costly insured health plan?"

In sum, this confusion and uncertainty over possible state regulation creates substantial problems for companies, like those represented by SIIA, that maintain self-funded health plans. It is this confusion that we ask this Court to now resolve by granting the requested writ.

#### **B. THE CONFLICT IN THE COURTS ADVERSELY AFFECTS THE ADMINISTRATION OF SELF-FUNDED PLANS.**

The conflict in the courts is having a significant adverse impact on the administration of thousands of self-funded plans, particularly those which are maintained in more than one state. Large and medium-sized employers which maintain self-funded plans typically operate on a national or multi-state basis.<sup>8</sup> Such plans, often administered by third-party administrators, need certainty that their programs will be

<sup>8</sup> Forty-three percent of medium-sized employers (250 to 999 employees) and eighty percent of large employers (5,000 to 50,000 or more employees) sponsor self-insured health plans. U.S. Department of Health and Human Services, *Health Care Financing Review*, Vol. 8, No. 8 (1986).

governed by a single set of laws, rather than varying rules decreed by courts in fifty different jurisdictions.<sup>9</sup>

The phenomenal growth in self-funded plans has been influenced to a great extent by the current system of uniform benefit plan administration fostered by ERISA. To subject such plans to the threat of often conflicting and inconsistent state insurance regulation—to say nothing of the threat of costly state judicial proceedings—will almost certainly result in piecemeal state regulation of such plans; rather than uniformity, chaos will prevail.

#### **C. THE THIRD CIRCUIT'S DECISION ADDS TO ESCALATING HEALTH COSTS AND THREATENS THE CONTINUED VIABILITY OF SELF-FUNDING AS AN ALTERNATIVE TO INSURED HEALTH PLANS.**

The *Metropolitan Life* case, provided a significant impetus to companies to self-insure employee health benefits. This growth reflects recognition of self-insurance not only as an alternative to insurance for funding health benefits, but also as a cost efficient method of responding to rapidly escalating health costs.

Important cost factors which have contributed to the growth of self-insurance within the present

<sup>9</sup> Self-funded plans provide health benefits to more than fifty percent of the workforce. Fifty-one percent of firms which maintain self-insured health plans utilize an outside third-party contract administrator to administer self-insured plans. During the five year period 1981-1985, enrollment in self-insured health plans of medium and large firms nearly doubled. Bureau of Labor Statistics, U.S. Labor Dept., *Annual Employee Benefit Survey* (1981-85).

ERISA regulatory framework include flexibility of plan design, greater control over claims, freedom from state insurance premium taxes and mandated benefits laws,<sup>10</sup> and cash flow advantages. Each of these factors results in a reduction of health benefit costs.

Typically self-funded plans contain coordination of benefit or subrogation provisions. Subrogation provisions generally involve plan recoveries for medical expenses paid by the plan for injuries sustained in automobile accidents, for product defects, accidents on private or public property and malpractice by hospitals and doctors, which are also paid to plan participants pursuant to legal action or settlement in civil cases. Subrogation recoveries do not reduce medical expenses which would otherwise be paid to plan participants in the absence of a third party recovery. By eliminating duplicative payments, self-funded health plans with subrogation clauses have contributed to a reduction of overall health costs for such plans. Accordingly, the ability to subrogate in such cases contributes to more cost-efficient administration of health plans and lower health benefit payments. Thus, the Third Circuit's decision below will add to escalating health costs and threatens the continued use of self-insured health benefit programs as a viable method of controlling health costs.

In sum, the threat of state interference in the administration of self-funded health plans with its attendant higher costs will continue until this Court settles the issue now before it.

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<sup>10</sup> Self-insured plans are not subject to state premium taxes. *Birdsong v. Olson*, 708 F. Supp. 792 (W.D. Tex. 1989).

## CONCLUSION

For the reasons set forth above, we urge the Court to grant the writ of certiorari so that these important and practical issues can be resolved.

Respectfully submitted,

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*Respondent.*

On Petition for a Writ of Certiorari to the United States  
Court of Appeals for the Third Circuit

BRIEF OF THE CHAMBER OF COMMERCE OF THE  
UNITED STATES OF AMERICA, AS AMICUS CURIAE,  
IN SUPPORT OF FMC CORPORATION'S PETITION  
FOR A WRIT OF CERTIORARI

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IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1989

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No. 89-1048

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FMC CORPORATION,  
*Petitioner,*  
v.

CYNTHIA ANN HOLLIDAY,  
*Respondent.*

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On Petition for a Writ of Certiorari to the United States  
Court of Appeals for the Third Circuit

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**BRIEF OF THE CHAMBER OF COMMERCE OF THE  
UNITED STATES OF AMERICA, AS AMICUS CURIAE,  
IN SUPPORT OF FMC CORPORATION'S PETITION  
FOR A WRIT OF CERTIORARI**

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**INTEREST OF AMICUS CURIAE<sup>1</sup>**

The Chamber is the largest federation of business, trade, and professional organizations in the United States. It represents the interests of over 180,000 cor-

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<sup>1</sup> This brief is being filed with the consent of the parties, pursuant to Supreme Court Rule 37.2. The consent letters have been filed with the Clerk of the Court.

porations, partnerships and proprietorships, as well as several thousand state and local chambers of commerce and trade associations. An important function of the Chamber is to represent the interests of its member employers in important labor relations matters before this Court, the lower courts, the United States Congress, the Executive Branch and independent regulatory agencies of the federal government. Such representation constitutes a significant aspect of the Chamber's activities. Accordingly, the Chamber has sought to advance those interests by filing briefs in a wide spectrum of labor relations litigation.<sup>2</sup>

The question presented by the instant case—whether a state anti-subrogation law may be applied to an uninsured employee welfare benefit plan—is of great concern to all Chamber member employers that maintain and operate self-insured employee benefit plans, and that contribute to self-insured, collectively bargained, multi-employer plans. The very large number of employer members that operate and/or contribute to such plans puts the Chamber in a position to provide the Court with a more complete understanding of the certain and unending problems the Third Circuit's decision will create in the area of employee welfare benefit plan regulation.

### SUMMARY OF ARGUMENT

In considering whether a state anti-subrogation law applies to an uninsured employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), the United States Court of Appeals for the Third Circuit expressly rejected this Court's view of ERISA preemp-

<sup>2</sup> *E.g.*, *Trans World Airlines, Inc. v. Independent Federation of Flight Attendants*, 109 S.Ct. 1225 (1989); *Laborers Health and Welfare Trust Fund v. Advanced Lightweight Concrete Co., Inc.*, 484 U.S. 539 (1988); *Pattern Makers League v. NLRB*, 473 U.S. 95 (1985).

tion of state laws. The Court of Appeals found Pennsylvania's anti-subrogation statute applicable to uninsured plans, and in so doing, ignored a critical distinction between insured and uninsured plans that was created by Congress and expressly recognized by this Court. While this Court clearly held that ERISA preempts the application of state laws to uninsured plans, the Third Circuit decision sets the stage for dual and conflicting state and federal regulation of these plans—a result which will necessarily lead to increased administrative and benefit costs. These increased burdens are precisely the types of state-created pressures which Congress sought to avoid through preemption.

The distinction between insured and uninsured plans for ERISA preemption purposes is supported by several factors. First, when Congress chose to "save" from preemption state laws regulating insurance, it was doing no more than continuing its historical deferral to state regulation in this area. Recognizing that the insurance industry had traditionally been subject to extensive state oversight, Congress vested regulation of the insurance industry in the states through enactment of the 1945 McCarran-Ferguson Act. Ch. 20, 59 Stat. 33 (1945). By contrast, when Congress enacted ERISA in 1974, it determined that adequate safeguards concerning the operation of employee benefit plans were lacking, thus making federal regulation of those plans desirable.

Second the nature and operation of employee benefit plans make it inappropriate for them to be subject to state insurance laws designed to regulate commercial businesses and to protect consumers. While insurance companies are businesses, selling consumer products to the public, welfare benefit plans are non-profit entities which exist to provide benefits only to a sponsoring employer's employees. They do not market their products to outside groups or to the public at large.

Third, Congress could not have accomplished its goal of eliminating the threat of conflicting and inconsistent employee benefit plan regulation without exempting uninsured plans from state regulation. Although a plan which purchases an insurance policy may rely on the insurance company to comply with any state laws affecting the company, an uninsured plan subject to state insurance laws would itself become responsible for sorting through various and conflicting state requirements.

Moreover, if upheld, the approach adopted by the Third Circuit, permitting a state law to apply to uninsured plans as long as the state law does not address "core ERISA concerns," would serve as an open invitation to the states to aggressively expand their regulation of employee benefit plans. Although ERISA, by its design, does not address many subjects, and although Congress expressly declined to extend even some of its "core" elements to employee welfare plans, this Court has recognized that the states are not free to fill in the gaps. If left unreviewed, the decision of the Court of Appeals will unleash a torrent of state legislative activity which could adversely affect millions of employees. Studies show that a large majority of welfare plans are uninsured. Increased regulation by the states will be devastating to the employers that have chosen to self-insure their plans, and will ultimately result in diminished coverage for workers and their dependents. This Court should grant the requested Writ to prevent this upheaval, and to reassert its analysis of the preemption of state laws relating to ERISA-covered plans.

## ARGUMENT

### THE WRIT SHOULD BE GRANTED BECAUSE THE THIRD CIRCUIT'S DECISION IGNORES THE COURT'S NECESSARY DISTINCTION BETWEEN INSURED AND UNINSURED PLANS—A LOGICAL DISTINCTION ROOTED IN HISTORICAL STATE REGULATION OF THE BUSINESS OF INSURANCE

This case centers on the distinction between insured and uninsured employee benefit plans. The distinction was created by Congress and reaffirmed by this Court in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985) ("*Metropolitan Life*"). Nevertheless, it was essentially ignored by the Third Circuit in the case below. In *Metropolitan Life*, this Court held that where an employee benefit plan purchases an insurance contract from an insurance carrier subject to state regulation, the plan may be subject to indirect state regulation because ERISA expressly excludes from its broad preemption provision state laws regulating insurance. 471 U.S. at 747; Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A).<sup>3</sup> Where an employee benefit plan is uninsured, however, it may not be subject to state insurance laws because ERISA expressly prohibits the states from deeming an employee benefit plan to be an insurance company or in the business of insurance for purposes of a state law regulating insurance. *Metropolitan Life*, 471 U.S. at 747; Section 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B).<sup>4</sup>

<sup>3</sup> Section 514(a) of ERISA generally provides that the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." Section 514(b)(2)(A), often referred to as the "savings" clause, states that except as provided in subparagraph (B), nothing in Title I of ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(a), (b)(2)(A).

<sup>4</sup> Section 514(b)(2)(B) of ERISA, known as the "deemer" clause, states that "Neither an employee benefit plan . . . nor any



The Third Circuit rejected the Court's recognition of a clear distinction in the application of ERISA's preemption provisions to insured and uninsured plans. In holding that Pennsylvania's anti-subrogation law applies to uninsured welfare plans, the Third Circuit followed the lead of the United States Court of Appeals for the Sixth Circuit in *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 108 S.Ct. 1754 (1988) ("*Northern Group Services*"), which upheld the application of coordination of benefits rules under a Michigan no-fault automobile insurance law to uninsured plans. Both of these Circuit Courts strained to reach a result preserving a uniform application of state laws to all employee benefit plans, "so that benefit obligations are governed by a rational system of state law and federal common law." *FMC Corp. v. Holliday*, 885 F.2d 79, 84 (3d Cir. 1989), *quoting Northern Group Services*, 833 F.2d at 89.

Yet, significant distinctions between the business of insurance and the operations of employee benefit plans motivated Congress to design a regulatory scheme under ERISA that specifically prohibited the application of state laws where true insurance is not involved. The Court should grant certiorari to prevent any further encroachment by the states, in the name of insurance regulation, on the exclusively federal area of employee benefit plans.

As an initial matter, when Congress chose to "save" from preemption state laws regulating insurance, it was doing no more than continuing its historical deferral to state regulation in this area. The insurance industry has traditionally been subject to extensive state regulation—

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trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . ." 29 U.S.C. § 1144(b) (2) (B).

indeed, Pennsylvania insurance legislation dates back to at least 1810. Pa. Stat. Ann. tit. 40 §§ 1 to 720, Introduction p. XXI (Purdon 1971). Congress long ago announced its intention to vest regulation of the insurance industry in the states. In 1945, Congress enacted the McCarran-Ferguson Act, Ch. 20, 59 Stat. 33 (1945), (codified as amended at 15 U.S.C. §§ 1011-1015 (1976 & Supp. V 1982)), declaring "that the continued regulation and taxation by the several states of the business of insurance is in the public interest." By contrast, Congress determined when it enacted ERISA that despite the recent growth in size, scope, and numbers of employee benefit plans, adequate safeguards concerning their operation were lacking, thus making federal regulation desirable. *See Findings and Declaration of Policy, Section 2(a) of ERISA*, 29 U.S.C. § 1001(a).

Further, allowing the states to continue to regulate insurance companies, while preventing them from regulating employee benefit plans, had a logical as well as historical basis. Insurance companies (which generally operate on a for-profit basis) are businesses, selling traditionally-regulated consumer products to unrelated customers. Insurance companies compete with each other for business, and advertise and market their products within the business community and to the public at large.

By contrast, uninsured employee welfare benefit plans are not in the business of selling consumer insurance products. They are non-profit entities which exist to provide benefits only to a sponsoring employer's employees. They do not market their wares to outside groups or to the public, and they do not attempt to broaden their base by selling coverage to unrelated beneficiaries. These distinctions more than justify Congress' refusal to permit the states to extend application of their traditional, consumer-protection insurance statutes directly to employee benefit plans.<sup>5</sup>

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<sup>5</sup> State insurance laws are commonly understood to be consumer protection statutes, regulating the sale of consumer products. *See*

Even more importantly, however, the Congressional goal of "eliminating the threat of conflicting and inconsistent State and local regulation"<sup>6</sup> of employee benefit plans could not have been accomplished without the comprehensive "deemer" clause. Allowing the states to regulate insurance companies did not threaten to burden employee benefit plans, even where those plans purchase insurance policies. However, Congress had to exempt uninsured plans from state regulation to ensure that the plans would not be overwhelmed by conflicting requirements.

When an employer or employee benefit plan purchases insurance from an insurance company, the plan does not itself become subject to state laws or responsible for determining the insurance company's compliance in various states. It is the insurance company's obligation to monitor the state laws that are applicable to it, and to make certain that the insurance contracts it sells are in compliance with those laws. Assumption of the administrative burden associated with differing state insurance laws is an essential component of the insurance product purchased by an employee benefit plan.

Thus, the states do not in fact regulate the employee benefit plans that purchase insurance policies. Rather, the insurance companies are regulated, and plans simply choose among the types of policies that the various states permit to be marketed.

By contrast, if the decision below is permitted to stand, and if state insurance laws are applied to uninsured em-

Collins, *Regulation Best on State Level*: Washburn, Bus. Ins. May 2, 1988, at 69; Howard, *States to Keep Ins. Regulation*, Nat'l Underwriter, June 26, 1989, at 3; Fisher, *Agents, Consumer Groups Seek Regulatory Standards*, Nat'l Underwriter, June 12, 1989, at 1; Jones, *The Industry Doesn't Need a Federal 'Czar'*, Nat'l Underwriter, November 7, 1988, at 19.

<sup>6</sup> 120 Cong. Rec. 29197 (1974), (statement of Rep. John Dent), quoted in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 99 (1983).

ployee benefit plans, the plans themselves will be required to monitor and comply with extensive state regulation. This Court has already found that Congress intended ERISA's preemption provision to eliminate "[a] patchwork scheme of regulation," because the inefficiencies introduced thereby "might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 11 (1987). As the Court recognized, "[p]reemption insures that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Id.*

If the states are permitted to apply their insurance laws directly to employee benefit plans, those plans and their sponsoring employers will be forced to shoulder the burden of the "patchwork scheme of regulation" which Congress intended to eliminate. Further, just as this Court predicted, the costs of compliance with a multitude of state laws may force some employers to reduce benefits and discourage others from adopting plans in the first place.

There can be no doubt that administrative costs for uninsured plans will increase if those plans must comply with various state insurance laws. One of the reasons that employers and plan trustees choose to self-insure is that the administrative costs for uninsured plans are generally lower than for insured plans.<sup>7</sup> In addition, employers insuring their own plans can achieve savings by holding onto cash until claims are paid, instead of paying premiums in advance to an insurer.<sup>8</sup> Despite these sav-

<sup>7</sup> Burcke, *Administrative Costs Lower Among Self Insurers: Study*, Bus. Ins., February 13, 1989, at 28, citing Foster Higgins, *Health Care Benefits Survey—1988*, at 24 (health care administrative expenses for self-insured employers total 5.2% of claims, while insured employers' administrative expenses total 6.6% of paid claims).

<sup>8</sup> Foster Higgins, *supra* note 7, at 23.



ings, however, there has been a dramatic upturn in medical plan costs.<sup>9</sup> Although this increase has affected both insured plans and uninsured plans, uninsured plans experienced its impact sooner.<sup>10</sup>

The negative financial impact of the decision below would not be limited to increased administrative costs, however. The Third Circuit analysis will also impose additional benefit costs on uninsured plans. These plans often operate with limited funds. Employers (and in the case of multiemployer plans, union and management trustees) select benefit levels and make coverage decisions in a manner designed to maximize the protection available to all plan participants. Subrogation rules and coordination of benefits provisions, like those held applicable to uninsured plans by the Third Circuit, and by the Sixth Circuit in *Northern Group Services*, 833 F.2d 85, serve to stretch an uninsured plan's limited dollars by restricting benefits to those individuals who have no other avenues of recovery. If state laws prohibit employers and plan boards of trustees from using these features of plan design, benefit costs will go up.<sup>11</sup>

The additional plan costs which will result directly from enforcement of the decision below could effectively

<sup>9</sup> Shalowitz, *Self Insurance—Self-Funding Benefits at Peak of Popularity?*, Bus. Ins., January 30, 1989, at 3.

<sup>10</sup> Foster Higgins, *supra* note 7, at 22.

<sup>11</sup> Perhaps the only alternative to increasing benefits in response to the Third Circuit decision would be to eliminate coverage for medical costs arising out of automobile accidents. See *Liberty Mutual Insurance Group v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384 (6th Cir. 1989) (coordination of benefits rules of Michigan no-fault insurance law preempted where health plan excluded coverage for automobile accidents). This completely unrealistic alternative would create a major gap in the protection of participants and beneficiaries under uninsured plans, and would raise employee morale issues which few employers and plan sponsors would consider acceptable.

eliminate the self-insurance option for employers and plans. This is precisely the type of state-created pressure Congress sought to avoid through preemption. See *Fort Halifax*, 482 U.S. at 11. The Court should take this opportunity to reaffirm the broad preemptive power of ERISA and to prevent the Third Circuit's opinion from threatening the existence of uninsured employee welfare benefit plans.

**THE WRIT SHOULD BE GRANTED AND THE THIRD CIRCUIT'S DECISION REVERSED IN ORDER TO PREVENT THE EXTENSIVE ADVERSE IMPACT OF A DECISION GRANTING THE STATES LICENSE TO REGULATE ANY AREA NOT CLASSIFIED AS A "CORE ERISA CONCERN"**

The Third Circuit's disregard of the Court's careful analysis of ERISA's preemption provision, "savings" and "deemer" clauses is so fundamentally erroneous that it would require reversal even without a consideration of the impact of the decision on the employee benefit plan community. Similarly, the substantial and direct conflict among the Courts of Appeals<sup>12</sup> (described in full in the Petition for A Writ of Certiorari) would justify this Court's intervention regardless of the ultimate number of employers and employee benefit plans that could be affected by the issue in dispute. What gives this case even greater significance, however, is the fact that unless this Court agrees to review the decision of the Third Circuit and strikes down its faulty preemption analysis, a large number of uninsured plans covering millions of this nation's employees will be adversely impacted. In addition, unless the Third Circuit's erroneous interpretation of ERISA's "deemer" clause is overturned, the states will feel free to go far beyond anti-subrogation laws and co-

<sup>12</sup> See, e.g., *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989) (ERISA preempts application of state subrogation law to self-insured benefit plan); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) (same).



ordination of benefits rules, and to impose the types of extensive (and potentially conflicting) regulatory requirements which Congress expressly determined should not apply to employee welfare benefit plans.

As to the extent of the potential impact of the decision below, studies show that the majority of Americans with group health coverage are covered by plans with some aspects of self-insurance.<sup>13</sup> One survey indicates that the percentage of uninsured plans may be as high as 66%.<sup>14</sup> In addition, many large multiemployer plans self-insure.<sup>15</sup> The growth in self-insurance has been attributed to ever-increasing health premium costs.<sup>16</sup> Clearly, the self-insurance option has been viewed by many employers as a manageable alternative to the purchase of expensive insurance contracts. If the desirability of this alternative is diminished as a result of the Third Circuit decision, the result may be reduced health benefits coverage for millions of employees.

After disparaging the Court's preemption test set forth in *Metropolitan Life*, 471 U.S. at 739-747, as "[s]tating the obvious more than providing guidelines," the Third Circuit ruled that ERISA's "deemer" clause will not pre-

<sup>13</sup> Donahue, *53% of Group Health Plans Are Now Self-Insured: HIAA*, Nat'l Underwriter, June 13, 1988, at 13 (based on a 1987 survey of 771 employers by the Health Insurance Association of America).

<sup>14</sup> The Wyatt Company, *A Survey of Health and Welfare Plans Covering Salaried Employees of U.S. Employers—1988, Group Benefits Survey—Summary Highlights*, at 32 (core employer group of 170 employers surveyed). See also Foster Higgins, *supra* note 7, at 23 (based on input of over 1600 employers with benefit programs covering over 10 million employees, 65% of employers with 1000 employees or more self-insure).

<sup>15</sup> Rappaport & Krist, *Actuarial Aspects of Self-Insured Taft-Hartley Welfare Plans: Reserves, Claim Forecasts and Setting Contribution Levels*, Empl. Ben. J., March 1986, at 14.

<sup>16</sup> Donahue, *supra* note 13, at 13.

vent application of a state insurance law to an uninsured employee welfare benefit plan unless the state law addresses a "core type of ERISA matter" or "core ERISA concerns." See *FMC*, 885 F.2d at 84, 88, 90. According to the Third Circuit, "core ERISA concerns" include the areas of reporting, disclosure, and nonforfeiture. See *FMC*, 885 F.2d at 88.<sup>17</sup> Thus, as long as a state law purporting to regulate "insurance" addresses areas other than reporting, disclosure and nonforfeiture of benefits, its provisions may be applied to uninsured employee welfare plans.

As this Court's prior decisions on ERISA preemption demonstrate, the "core ERISA concerns" approach adopted by the Third Circuit could not have been a result intended by Congress. Although ERISA imposes comprehensive requirements on employee pension benefit plans, Congress deliberately did not regulate health and welfare plans as extensively. Welfare plans were expressly excluded from the complex and finely-tuned provisions on vesting, participation, benefit accrual, minimum funding, and plan termination insurance applicable to pension plans. See Sections 201(1), 301(a)(1), and 4021(a)(1) of ERISA, 29 U.S.C. §§ 1051(1), 1081(a)(1), 1321(a)(1). Yet, Congress' failure to extend all aspects of ERISA regulation to welfare plans cannot be construed to give the states authority to roam. As this Court has recognized:

Nor, given the legislative history, can § 514(a) be interpreted to pre-empt only state laws dealing with

<sup>17</sup> Although the opinion is far from clear, the Third Circuit's discussion of the legislative history of ERISA's preemption provision suggests that the area of fiduciary responsibility would also be a "core ERISA concern." See *FMC*, 885 F.2d at 87-88. In addition, the Third Circuit's designation of nonforfeiture as a "core ERISA concern" suggests that other subject areas covered by ERISA, but which (like nonforfeiture) are not applicable to welfare plans, might also be considered "core" matters. See Section 201(1) of ERISA, 29 U.S.C. § 1051(1) (excluding employee welfare benefit plans from ERISA's nonforfeiture rules).

the subject matters covered by ERISA—reporting, disclosure, fiduciary responsibility, and the like. The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected these provisions in favor of the present language and indicated that the section's pre-emptive scope was as broad as its language.

*Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983).

It was the broad scope of ERISA preemption that the Court focused on in *Metropolitan Life* when it held that mandated benefit laws do not apply to uninsured plans, even where they are drafted as state insurance laws "saved" from ERISA preemption. Mandated benefit laws generally do not address the areas of reporting, disclosure, or nonforfeitable, and, indeed, go far beyond any ERISA requirement applicable either to welfare or pension plans.<sup>18</sup> Would the Third Circuit analysis lead to the conclusion that mandated benefit laws thus do not address "core ERISA concerns"? If so, even the state law discussed by this Court in *Metropolitan Life* could be found not to be preempted by ERISA.

Even more disturbing is that in rushing to its desired judgment, the Third Circuit failed to recognize that a state anti-subrogation law in fact addresses the "core ERISA concern" of nonforfeitable. The Pennsylvania antistubrogation law at issue in this case prohibits any right of subrogation or reimbursement from a participant's tort recovery with respect to medical claims paid. See 75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1984). It essentially requires plans to treat a health benefit as "vested"—immune from certain reimbursement claims by

<sup>18</sup> ERISA leaves the question of which benefits will be provided under a plan to the private parties creating it. See *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).

the plan, and, therefore, nonforfeitable.<sup>19</sup> Even if the Third Circuit's approach could be sustained under the reasoning of this Court's prior decisions, the proper analysis would lead to the preemption of Pennsylvania's anti-subrogation law on the ground that it improperly requires vesting of welfare plan benefits. That the Third Circuit did not even address this point demonstrates the danger in allowing to let stand a preemption test that would give wide latitude to the states and the lower courts in determining what is central to ERISA and what is not.

If left undisturbed, the Third Circuit decision will serve as an open invitation to expansive state regulation of employee welfare plans. Indeed, it would be difficult to predict the ingenuity which the states could apply in devising creative new requirements for plan regulation which could fit within the Third Circuit analysis. One can assume, however, that various (and conflicting) anti-subrogation rules and coordination of benefit laws will be imposed throughout the states, along with rules relating to benefits processing and the timeliness of payment of claims.<sup>20</sup> The states may also attempt to impose

<sup>19</sup> Cf. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (New Jersey law prohibiting offset of pensioner's workers' compensation benefits against his pension is preempted by ERISA; although offset would ordinarily constitute impermissible forfeiture under ERISA, it is specifically permitted under lawful regulations of Internal Revenue Code). Congress, of course, expressly declined to extend ERISA's vesting requirement to health and welfare benefits. See *In Re: White Farm Equipment Co.*, 788 F.2d 1186 (6th Cir. 1986) (no absolute rule requiring mandatory vesting of retiree medical benefits; Congress expressly exempted welfare plans from stringent vesting, participation and funding requirements). See also *Metropolitan Life*, 471 U.S. at 732 (ERISA does not regulate substantive content of welfare benefit plans), citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 91.

<sup>20</sup> See, e.g., Ill. Ann. Stats., Chap. 73 §§ 964, 969 (Smith-Hurd 1988); Ohio Rev. Code Ann. § 3901.38 (Anderson 1989); Tenn. Code Ann. § 68-11-219 (1988).

minimum asset (actuarial reserve) requirements and other traditional "insurance" obligations on uninsured plans.<sup>21</sup> Uninsured plans covering participants in more than one state will be thrust into the state law compliance business, forced to sort through new and conflicting requirements, all in contravention of the federally-designed scheme of uniform employee benefit plan regulation.

Accordingly, Amicus Curiae urges this Court to grant the Writ to resolve the irreconcilable differences between the Third Circuit's treatment of the case below and the contrary views expressed by this Court, Congress, and the other Courts of Appeals which have addressed this issue; and to prevent the certain adverse impact on welfare plans which will result from this unwarranted expansion of state regulation.

<sup>21</sup> See, e.g., Pa. Stat. Ann. tit. 40 § 93 (Purdon 1971).

## CONCLUSION

The potential impact of the Third Circuit's decision demonstrates why this Court should once again address the scope of ERISA's preemption provisions. If left undisturbed, the decision below will disrupt ERISA's carefully-constructed scheme of uniform federal regulation, and will threaten the viability of the nation's uninsured welfare benefit plans. This Court should grant the Writ to remove that threat.

For the foregoing reasons, Amicus Curiae, the Chamber of Commerce of the United States, urges that the petition of FMC Corporation be granted.

Respectfully submitted,

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No. 89-1048

IN THE  
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OCTOBER TERM, 1989

FMC CORPORATION,  
v. *Petitioner,*CYNTHIA ANN HOLLIDAY,  
*Respondent.*On Petition for a Writ of Certiorari to the  
United States Court of Appeals  
for the Third Circuit**AMICI CURIAE BRIEF OF  
THE TEAMSTERS HEALTH AND WELFARE FUND  
OF PHILADELPHIA & VICINITY,  
THE WESTERN PENNSYLVANIA TEAMSTERS AND  
MOTOR CARRIERS WELFARE FUND,  
THE DAIRY INDUSTRY-UNION HEALTH AND  
WELFARE FUND OF PHILADELPHIA & VICINITY,  
IBEW LOCAL UNION NO. 98 HEALTH AND  
WELFARE FUND, AND CENTRAL PENNSYLVANIA  
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IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI**

**INTEREST OF THE AMICI CURIAE**

In *FMC Corporation v. Holliday*, 885 F.2d 79 (3d Cir. 1989), the Third Circuit upheld the validity of a Pennsylvania anti-subrogation statute which had been challenged as preempted by § 514 of the Employee Retirement Income Security Act, 29 U.S.C. § 1144. The court employed a three-pronged analysis, finding that the state statute was: (1) initially preempted by ERISA § 514 (a), 29 U.S.C. § 1144(a); (2) withdrawn from preemption by the "savings clause" for state laws which regulate insurance, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A); and (3) not re-subjected to preemption by the "deemer clause" of ERISA § 514(b)(2)(B), 29 U.S.C. § 1144b)(2)(B). The facts of the case and the Third Circuit's analysis are fully set forth in FMC Corporation's petition for writ of *certiorari*.

This brief in support of the petition is submitted on behalf of five multiemployer welfare plans (collectively designated the "Funds") which are based in Pennsylvania and, thus, directly affected by the statute sustained by the Third Circuit.<sup>1</sup> Each Fund is administered by Trustees, appointed in equal numbers by management and labor, who owe their exclusive fiduciary obligations

<sup>1</sup> The Funds are established pursuant to § 302(c)(5) of the Labor Management Relations Act, 29 U.S.C. § 186(c)(5), ("LMRA") and § 3(1) and (37) of ERISA Act, 29 U.S.C. §§ 1002(1) and (37) ("ERISA").

to that Fund's participants and beneficiaries. See *NLRB v. Amax Coal Co.*, 453 U.S. 322, 332-34 (1981). The Funds are financed by contributions which are paid at rates negotiated by constituent unions and employers. *United Mine Workers of America Health & Retirement Funds v. Robinson*, 455 U.S. 562, 570-76 (1982). Therefore, unlike insurance companies, the Funds have no independent power to increase their incoming contributions.

The Funds have two critical interests in this case. First, each Fund has a subrogation provision which is essentially identical to the clause invalidated in the FMC Corporation plan. These subrogation provisions are designed to preserve finite trust assets by preventing duplicative compensation for one injury, a practice which is colloquially known as "double dipping." If *Holliday* remains intact, the Funds' ability to prevent "double dipping" will be greatly impaired, and less money will be available to provide benefits for participants and beneficiaries who have no source other than the Funds for medical benefits.<sup>2</sup>

Second, and perhaps more ominously, the logic of the Third Circuit's opinion would subject self-funded benefit plans, such as the Funds, to open-ended state interference with cost containment practices. That result would totally flout the policies underlying ERISA and, in today's economy and political climate, would constitute a disaster for the Funds and other similarly-situated benefit plans.

<sup>2</sup> The impact of this outcome cannot be minimized, regardless of whether the case is viewed from the perspective of the Funds or on a national basis. The Pennsylvania statute sustained by the Third Circuit guarantees duplicative compensation for injuries arising from automobile accidents in which tort recoveries are secured. As shall be explained at note 13 *infra*, and accompanying text, tens of billions of dollars are spent each year in the United States for medical care and disability arising from automobile accidents. Obviously, the potential for "double dipping" is enormous.

### A. THE THIRD CIRCUIT'S DECISION WOULD DIVEST THE FUNDS OF AN IMPORTANT COST CONTAINMENT MEASURE.

The exploding cost of medical care is causing a national crisis. Self-insured benefit plans must respond with effective measures to contain costs. The Funds' subrogation policies are precisely the type of cost containment provision mandated by the present crisis. The Third Circuit's challenge to subrogation hampers the cost containment effort and, thus, threatens the Funds, their participants, and their beneficiaries.

#### 1. The National Health Care Crisis.

In 1988, the Congressional Research Service of the Library of Congress conducted a study on health care in the United States at the request of the House of Representatives' Committee on Education and Labor and the Senate's Special Committee on Aging. According to the final report:

. . . During the 1980's premium rates [for health insurance] increased rapidly, but the increase slowed between 1984 and 1987. However, *increases for 1988 and 1989 are expected to resume the high growth rate of the early 1980's.*

In 1977, the average monthly premium for enrollee coverage was \$25 and the average for family coverage was \$65. Taking into account medical care inflation as indicated by the medical care portion of the CPI, these premiums would have been equal to \$57 for individuals and \$148 for family. In 1987, the average enrollee premiums had risen by 35 percent in real terms to \$77 and family premiums had risen to \$201.

Congressional Research Service, Library of Congress, *Health Insurance and the Uninsured: Background Data and Analysis*, pp. 65-66 (1988) (emphasis added).

The prediction of renewed inflation after 1987 came true with a vengeance. According to the United States Chamber of Commerce, the cost of providing medical cov-



erage to employees rose by 19% in 1988. Geisel, *Health Benefit Tab Rises 19% to New High*, Business Insurance, December 11, 1989 at 1. In 1989, costs for multiemployer funds skyrocketed on a national basis by between 20% and 40%.<sup>3</sup> According to the AFL-CIO, in the future "health care costs will continue to rise anywhere from 18 to 31 percent per year." DeWolf, *Health Care Benefits A Continuing Issue*, Philadelphia Daily News, January 12, 1990 at 81, 82.

The extent of the crisis is graphically demonstrated by the degree to which it has generated labor-management turmoil. The cost of health care was the most divisive issue of the nine-month strike in Appalachia which the United Mineworkers conducted against Pittston Coal Company. Indeed, on the day of the settlement, Labor Secretary Elizabeth Dole announced that a special federal commission would be appointed to study the problem of health care costs. Kilborn, *Dole Winning Applause for Labor Department Actions*, New York Times, January 4, 1990 at 16, col. 1.<sup>4</sup>

<sup>3</sup> During the first half of 1989, inflation for multiemployer plans averaged "20-22% annually for medical care and about 13% for dental care." Johnson, *Flexible Benefits for Multiemployer Plans*, Employee Benefits Journal, June 1989 at 31. Later that year, costs rose "an average of 20-40%." Grossi, Yu, Astor & McCarthy, *The Pre-Estimate Program: An Effective Way to Reduce Surgical Fees While Preserving High Quality Care and Patient Choice*, Employer Benefits Journal, December 1989 at 2. See also, Geisel, *Repeal of Section 89 Most Important Event for Benefit Managers*, Business Insurance, December 25, 1989 at 3 ("In 1989, health care costs for indemnity plans increased 20% to 50%, while health maintenance organizations boosted premiums about 17% on average, several surveys found"); Gaul, *Area Hospitals Undergo A Shakeout*, Philadelphia Inquirer, January 16, 1990 at 1-A, 9-A, col. 3 ("Nationally health care expenditures rose from \$248 billion in 1980 to a projected \$647 billion in 1990—a 160 percent increase in a decade").

<sup>4</sup> Health care costs sparked many other disputes in 1989, including strikes by 60,000 employees of Nynex Corporation; 140,000 employees of regional Bell Telephone Companies; 2,100 Borg-Warner employees in Indiana, and 1,000 workers at Post Cereal Company's facility in Battle Creek, Michigan. Verespej, *Rx For Costs Elusive*, Industry Week, December 4, 1989 at 88.

The causes of this rampant inflation in medical costs have not been conclusively identified. Different authorities cite factors including: (1) modern technology (which is expensive and prolongs treatment by causing patients to live longer),<sup>5</sup> (2) the effect of mandated benefits laws,<sup>6</sup> (3) increased substance abuse in the workforce,<sup>7</sup> and (4) the onset of AIDS.<sup>8</sup>

<sup>5</sup> Handel, *The Renewed Surge in Health Care Inflation*, Employee Benefits Digest, December 1988 at 7-8; Katz, *Fear and Trembling on Benefits Trail*, National Underwriter Property & Casualty/Employee Benefits Edition, December 5, 1988 at 9; Adler, *Radical Changes in Benefits Loom*, Business Insurance, November 7, 1988 at 14.

<sup>6</sup> By mid-1989, 34 states had adopted laws requiring insurers to provide certain types of benefits (e.g., chiropractic services) in order to do business in those states. Such laws tend to increase the price of health care throughout the entire jurisdiction, because they encourage providers to raise their fees to meet the mandated benefit levels and consumers to increase usage. Haistmaier, *Why America's Health Care System Is In Crisis*, Heritage Foundation Report, May 30, 1989 at 1.

<sup>7</sup> One author has noted the following:

A dramatic rise in mental health care costs and utilization has been experienced in recent years by employers in terms of out-of-pocket payments for care and of lost productivity due to drug and alcohol abuse and other mental health problems in the work-force. Between 1985 and 1987, psychiatric and substance abuse costs to employers increased 45 percent nationwide. The costs are now rising at about twice the general rate of medical inflation.

Hastings, *Legal Developments in Managed Mental Health Care*, Physician Executive, November-December 1989 at 36. See also Diesenhouse, *Drug Treatment Is Scarcer Than Ever For Women*, New York Times, January 7, 1990 at 26 ("[I]t has been estimated that while there are approximately 17.7 million adults with severe alcohol problems and 9.5 million drug users, only 615,000 people are in treatment, with at least 70,000 on waiting lists"); Adler, *Employers Shift Focus to Controlling Costs of Mental Health Care*, Business Insurance, February 20, 1989 at 17 ("Some 20% to 25% of all employer health care expenditures go toward psychiatric and substance abuse treatment . . .").

<sup>8</sup> According to a study conducted by the Alexander & Alexander Consulting Group in early 1988, when the recent health care inflation was just beginning, "[t]he average per-case cost for

Though the causes may be disputed, there is no doubt that drastic action is necessary. The Federal Government has completely revamped its billing procedures in order to cut Medicare and Medicaid costs.<sup>9</sup> Several prominent industrialists, including Chrysler Corporation Chairman Lee Iacocca, have suggested that the only effective remedy may be socialized medicine. Nelson-Hurchler, *U.S. Catching Socialism?*, Industry Week, August 21, 1989 at 45.

## 2. The Need for Effective Cost Containment Policies.

As previously indicated, multiemployer benefit plans have no power to raise their contribution levels to meet the current waive of health care inflation. These levels, determined through the collective bargaining process, are fixed for the duration of the governing labor agreements and are limited by what the contending negotiators are willing or able to pay.<sup>10</sup> Therefore, multiemployer plans

treatment of AIDS was \$103,350." Kittrell, *Large Employers Report More AIDS Cases: Survey*, Business Insurance, February 8, 1988 at 3. These costs will increase as AIDS patients live longer (and thus require more treatment) due to increasingly effective therapies, such as administration of AZT. Chase, *People With AIDS Live Longer Now, Studies Confirm*, Wall Street Journal, January 19, 1990 at B2, col. 7. Pennsylvania, the state directly affected by the *Holliday* opinion, ranks seventh in the nation in the number of reported AIDS cases. Report of the Pennsylvania Bar Association Risk Force on Acquired Immune Deficiency Syndrome at 15 (November 11, 1989).

<sup>9</sup> Title VI of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, sets forth new amendments designed to cut costs for Medicare and Medicaid. Title VI contains over 100 sections which govern numerous matters, e.g., physician fee schedules, durable equipment, mental health services, nursing services.

<sup>10</sup> Many multiemployer plans are in industries which are either financially depressed or increasingly non-union. Since employers which contribute to such plans are often financially stressed, they have difficulty in making adequate benefit contributions. Katz, *Meltdown Forces New Look At Benefit Plan Structure*, Life & Health/Financial Services Edition, January 4, 1988 at 14. The current industrial strife caused by health care inflation further demonstrates

have only two alternatives for dealing with the present inflation in health care, viz., to cut costs and to reduce benefits.

Experts unanimously agree that, to cut costs, ERISA plans must maximize the buying power of their assets. Cynthia K. Hosay, Ph.D., vice president of health services and health care with Martin E. Segal Co., the nationally recognized consulting firm, explains that "[d]uplication in care is costly." Hosay, *Negotiating with Health Care Providers*, Employees Benefits Journal, March 1989 at 3. To contain costs, benefit plans must limit needless and duplicative expenditures by adopting programs such as: (1) a centralized record system to avoid repetitive diagnostic testing, (2) second opinion and utilization review programs, to prevent needless treatment, (3) increased resort to less costly treatment options, e.g., outpatient care, (4) education of participants to help them avoid sickness, and (5) direct negotiations with health providers, such as hospitals, druggists, and physicians, in order to cut prices through volume discounts, preferred provider organization arrangements, and *per diem* contracts. Dr. Hosay's opinion is in accord with both the consensus of experts,<sup>11</sup> and the policies underlying ERISA. The Congressional Findings and Statement of Policy which begin the statute specifically state that securing the "financial soundness" of benefit plans is a primary purpose of the legislation. ERISA § 2(a), 29 U.S.C. § 1001(a).

the uncertainty inherent in relying upon the collective bargaining process. See *supra* note 4, and accompanying text.

<sup>11</sup> E.g., Sizemore, *Concerns on Cost Lead to Innovation*, Pension & Benefits, Fall 1989 at 13; Haggerty, *Direct Health Contracting Curbs Costs: Consultant*, National Underwriter Property & Casualty/Employee Benefits Edition, May 22, 1989 at 21; Cave, *Direct Contracting With Hospitals: Alternative Payment Arrangements*, Employee Benefits Journal, June 1989 at 26; Ozzie and Harriet *Package of Employee Benefits Funds*, Chicago Tribune, January 1, 1989 at 37; Gannes, *Strong Medicine for Health Bills*, Fortune, April 13, 1987 at 70.



### 3. *The Threat to Cost Containment.*

The Funds' subrogation provisions which would be effectively invalidated by the Third Circuit's decision in *Holliday* are simply another type of cost containment measure. The goal is to conserve trust assets by preventing (or recouping) expenditures which are not necessary to provide benefits, because the plan participant or beneficiary has secured compensation from a tortfeasor. Stated simply, subrogation attacks "double dipping."

The concept is hardly radical. The Funds' subrogation policy is highly analogous to 'coordination of benefits,' a practice which prevents duplicative compensation by prorating benefit payments between or among different insurers or benefit plans. The right to coordinate benefits is well-recognized in the context of insurance law. 8A Appleman, Insurance Law and Practice §§ 4906-010, at 341-492 (1981); 16 Couch on Insurance 2d (Rev ed) §§ 62.41-62.188, at 475-657 (1983). Coordination should be even more appropriate for self-insured ERISA plans, where the savings translate into benefits for other employees, as opposed to increased profits for insurance companies.<sup>12</sup> The only difference between coordination of benefits and the Funds' subrogation rules is that the latter reduces expenditures in accordance with the amount paid by tortfeasors, rather than other benefit plans. The end result is the same, *i.e.*, more assets for other participants and beneficiaries.

If the Third Circuit's position in *Holliday* remains intact, the Funds will be compelled to pay out hundreds of

<sup>12</sup> Ironically, the Third Circuit is the only court which has considered the extent to which coordination of benefits is applicable to ERISA. In *Northwest Department ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229*, 764 F.2d 147 (3d Cir. 1985), the court indicated that coordination of benefits provisions are valid as long as they do not cause a participant to receive less than he or she would receive in the absence of alternate coverage. *Id.* at 161-62 & n.13. The Funds' subrogation provisions, which only seek to prevent or recoup payments actually received from another source, would clearly pass muster under this test.

thousands, perhaps millions, of dollars to "double dipping" participants and beneficiaries whose claims stem from automobile accidents.<sup>13</sup> These duplicative payments could only be provided in one manner—reducing the trust assets available to provide benefits for participants and beneficiaries who cannot "double dip." To put it bluntly, every dollar lost through "double dipping" will translate into one less dollar available for hospital patients, pregnant mothers, AIDS patients, the long term disabled, and other persons who have no other source of care. To prevent this ridiculous result, which makes a mockery of ERISA's goal to provide employees with quality medical care, this Court should grant the petition for writ of *certiorari*.<sup>14</sup>

<sup>13</sup> The exact amount which subrogation saves benefit plans varies with time, depending upon the number of accidents, the size of the recoveries, and the solvency of the tortfeasors. *Holliday*, for example, is a case where the tortfeasor had limited insurance coverage and an obligation to pay multiple plaintiffs. Nevertheless, the plan could have saved approximately \$50,000 through subrogation. Thus, only a handful of accidents of this type can involve hundreds of thousands of dollars.

The widespread litigation which this issue has generated graphically demonstrates that ERISA plans view subrogation as an effective cost containment measure. This is not surprising in light of the staggering cost of automobile related injuries, which are only one type of injury governed by subrogation.

In 1985, the lifetime cost of medical and disability benefits arising from motor vehicle injuries in the United States amounted to \$48,683,000,000. Rice & MacKenzie, *Cost of Injury in the United States: A Report to Congress* at 44 (1989). Figures are not available for subsequent years. Estimating an annual rate of increase at 10%, the figures would be: \$53,551,300,000 in 1986; \$58,906,430,000 in 1987; \$64,797,073,000 in 1988; and \$71,276,780,000 in 1989. These figures are conservative in light of roaring rates of inflation currently experienced in health care.

<sup>14</sup> The Third Circuit's decision is anomalous in another respect. Fiduciaries of a trust fund have a common law duty to treat all beneficiaries impartially. Restatement (Second) of Trusts § 183. Under ERISA, this principle has been expanded to require even handed treatment designed to secure "the greatest good for the greatest number." Silverman, *Legal and Ethical Responsibilities*



**B. THE THIRD CIRCUIT'S DECISION THREATENS TO SUBJECT THE FUNDS, AND OTHER SELF-INSURED BENEFIT PLANS, TO UNFETTERED STATE INTERFERENCE WITH COST CONTAINMENT POLICIES.**

The *Holliday* opinion's challenge to sound cost containment policy is by no means limited to the specific mechanism of subrogation. According to the Third Circuit, state insurance laws are only preempted to the extent that they involve "core" ERISA concerns, such as rules governing "reporting, disclosure, and non-forfeitability" of rights. *FMC Corp. v. Holliday*, 885 F.2d at 88. While the Third Circuit's definition of "core" concerns is murky, the very holding of *Holliday* excludes cost containment measures, such as subrogation, from "core" concerns. This relaxed definition of ERISA preemption is very significant, because many cost containment measures are presently under siege in state courts and legislatures.

The reason for this siege is simple, viz. cost containment causes "a loss of revenue to health care providers." Handel, *supra* at 7. Health care providers, in turn, have counterattacked, often resorting to state law.

Pennsylvania, for example, is experiencing an assault upon the ability of benefit plans to negotiate exclusive dealing arrangements with certain pharmacists in exchange for volume discounts. As previously explained, arrangements of this nature are strongly recommended

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of Health and Welfare Fund Trustees, Employee Benefits Digest, February 1989 at 3, 5. See *District 2, UMW v. Helen Mining Co.*, 762 F.2d 1155, 1160-61 (3d Cir. 1985), cert. denied, 474 U.S. 1006 (1985).

The Pennsylvania statute in this case discriminates in favor of persons injured in automobile accidents, by granting them a special exemption from subrogation, while victims of other accidents can be denied duplicative recoveries. This disparate treatment is totally inconsistent with ERISA.

by experts in the health field as an effective means for maximizing an ERISA plan's purchasing power. See *supra* note 11, and accompanying text. Fearing that these arrangements will succeed in cutting the cost of prescriptions, a lobbying group for druggists named the Pennsylvania Pharmaceutical Association has proposed legislation to prevent insurance companies and ERISA plans from negotiating such contracts. This legislation has broad support. Benson, *Pharmacy Bill Would Target Private Pacts*, Pittsburgh Business Times & Journal, June 19, 1989 at 15. If the legislation passes and is challenged on the basis of ERISA preemption, the legislation's proponents would certainly cite *Holliday* for the proposition that cost containment measures are not preempted. Success on such an argument would rob the Funds of another important method to contain costs (and, thus, to maximize benefits).

Similarly, in *Varol v. Blue Cross & Blue Shield*, 708 F. Supp. 826 (E.D. Mich. 1989), a group of physicians argued that Michigan law prohibited a variety of widely-recognized procedures crafted to prevent unneeded or duplicative medical procedures, e.g., preauthorization and concurrent utilization reviews. The court ruled against the physicians on the ground that ERISA preempted the state law in question. The Third Circuit's analysis, however, could lead to a contrary result with regard to any state laws inconsistent with such cost containment policies. In that event, the physicians' lobby would be an additional threat to the Funds and other self-funded benefit plans.

Yet lawyers probably pose the most potent threat to cost containment. The hostility of the plaintiff's bar to certain forms of cost containment is demonstrated by the *amicus curiae* brief which the Pennsylvania Trial Lawyer's Association ("PTLA") filed in *Holliday*. 885 F.2d at 85. Trial lawyers, moreover, are a powerful force on the state law level. In Pennsylvania, for example, they

have played a major role in shaping automobile insurance laws, the source of the "double dipping" provision which gave rise to this litigation. Cohn, Fish & Enda, *How Interest Groups Mold Pa.'s Auto Insurance System*, Philadelphia Inquirer, October 23, 1989 at 1-A, col. 1 ("[T]oday, as in 1983 [when the current automobile legislation was enacted], a large part of the decision-making process has fallen under the influence of . . . the trial lawyers who profit tremendously from the state's insurance system"); Statement of State Representative Andrew J. Carn, PR Newswire, January 10, 1990 (available on NEXIS) (identifying the Pennsylvania Trial Lawyers Association as one of the organizations which "wrote the present laws governing auto insurance in . . . Pennsylvania").

During the legislative debate on ERISA, Senator Williams delivered the report of the Conference Committee to the full Senate. His remarks at that time included a discussion of ERISA preemption. He observed that "[s]tate professional organizations acting under the guise of state-enforced professional regulation, should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized." 120 Cong. Rec. 23,933 (1974). As a floor manager of ERISA, Senator Williams' comments merit considerable weight. Indeed, the Third Circuit's opinion recognized the Senator's statement as an accurate expression of the Congressional intent underlying ERISA. 885 F.2d at 87. This recognition is ironic since the logic of *Holliday* would place self-funded ERISA plans at the mercy of state laws enacted or invoked by "state professional organizations."

## SUMMARY OF ARGUMENT

This Court should grant the writ of *certiorari* for two reasons, apart from those already set forth in the pending petition. *First*, in 1982 Congress amended ERISA to exempt the Hawaii Prepaid Health Insurance Act from the preemptive scope of § 514. The language and legislative history of that provision prove that the "deemer clause" of ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), was intended to exempt self-insured plans from regulation by the other forty-nine states. *Second*, cost containment measures such as subrogation do not constitute the business of "insurance" under the "savings clause" of ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). Hence, the Pennsylvania statute should be preempted regardless of the interpretation given to the "deemer clause."

## REASONS WHY THE WRIT SHOULD BE GRANTED

The petition for writ of *certiorari* sets forth several important reasons for granting the writ, particularly: (1) the need to resolve the split in the Circuits, and (2) the flat inconsistency between *Holliday* and this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 746 (1985). Indeed, the clash with *Metropolitan Life* is so serious that the Third Circuit's decision is a candidate for summary reversal, *e.g.*, *Stone v. Graham*, 449 U.S. 39 (1980).

The Funds endorse the arguments contained in the petition and will not repeat them. There are, however, additional reasons for granting the writ.

### I. THE THIRD CIRCUIT'S INTERPRETATION OF ERISA PREEMPTION IS DISCREDITED BY THE AMENDMENT OF ERISA CONTAINED IN THE PERIODIC PAYMENT SETTLEMENT ACT OF 1982.

The Third Circuit's decision in this case springs from a fundamental misreading of the "deemer" clause in ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B).



As this Court correctly observed in *Metropolitan Life*, 471 U.S. at 747, that clause insulates self-insured plans from state regulation. In *Holliday*, conversely, the Third Circuit concluded that the clause only protects "core ERISA concerns," a term which the court never clearly defined. 885 F.2d at 88. This analysis is inherently flawed as nothing in the language or legislative history of ERISA limits the deemer clause to "core" matters.

Any lingering doubt over the issue is dispelled by an amendment to ERISA contained in the Periodic Payment Settlement Act of 1982 "(PPSA)", codified in § 514(b)(5) of ERISA, 29 U.S.C. § 1144(b)(5), which provides that the preemption provisions of ERISA "shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51)." The establishment of this specific exception for Hawaii illustrates the full breadth of preemption which governs other states.

The PPSA must be read in light of two significant cases which preceded it. In *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir. 1978), *cert. denied*, 439 U.S. 831 (1978), the Ninth Circuit held that a California statute was preempted to the extent that it affected a self-insured employee benefit plan. The court explained that "[a]lthough Section 514(b)(2)(A) exempts from preemption state regulation of insurance, Section 514(b)(2)(B) provides that *employee benefit plans may not be considered to be in the business of insurance for purposes of the exception to preemption*." 571 F.2d at 504 (emphasis added). In short, the Ninth Circuit adopted an interpretation of the deemer clause which flatly exempts self-funded plans from state law and, thus, contradicts the position which the Third Circuit would later take in *Holliday*.

One year after *Hewlett-Packard*, the Ninth Circuit considered the affect of ERISA preemption upon the Hawaii Prepaid Health Care Act, which required employers doing business in Hawaii to furnish employees with certain mandated benefits. *Standard Oil of Cali-*

fornia, which maintained a self-funded plan for its employees in that state, brought a declaratory judgment action, arguing that the Hawaiian legislation was preempted by ERISA. Citing *Hewlett-Packard*, the Ninth Circuit agreed that the state statute was preempted. *Standard Oil of California v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1979), *aff'd mem.*, 454 U.S. 801 (1981). Hawaii then sought relief in Congress.

On October 1, 1982, Senator Robert Dole of Kansas reported the PPSA to the Senate on behalf of the Finance Committee. He noted that the bill "includes four provisions, each of merit and I believe noncontroversial." Senator Dole then introduced Senator Spark Matsunaga of Hawaii who discussed one of these provisions, *i.e.*, "a committee amendment which rescues the Hawaii Health Care Act from preemption by the Employee Retirement Income Security Act of 1974." 128 Cong. Rec. 26,902 (1982). Senator Matsunaga discussed the *Standard Oil of California* litigation, describing the ultimate judicial determination that "the broad language of ERISA preempted all state law relating to private employee benefit plans including Hawaii's Prepaid Health Insurance Act." 128 Cong. Rec. 26,903 (1982). He noted that, in 1979, Congress failed to pass a bill designed "to exempt from preemption state health insurance law" throughout the nation, and that opponents of the *Standard Oil of California* decision had then limited their efforts to exempting "only the Hawaii statute." With no further debate on the issue, the Senate passed the bill unanimously.

On December 13, 1982, Congressman Rostenkowski introduced the PPSA to the House of Representatives. He noted that the House Committee on Education and Labor had amended the Senate's Hawaiian exemption by including language "to the effect that the exception made by this legislation is not to be considered a precedent for extending the exception to other state laws." 128 Cong.



Rec. 30,352 (1982). Congressman Erlenborn then made the only significant speech on the Hawaiian proviso, in which he gave the following explanation of the legislation:

Last year the Supreme Court let stand the decision of the Ninth Circuit Court of Appeals in *Standard Oil of California* against Aghsalud that the broad preemptive framework relating to pension and welfare (for example, health) plans agreed to by the ERISA conferees does in fact supersede the Hawaii statute. The agreement to amend ERISA to permit the future application of the Hawaii law was reached solely on the basis and with the understanding that *the Hawaii law is an unusual special case*, inasmuch as the law was enacted just prior to the signing of ERISA on September 2, 1974, and that the law will be permitted to operate only as a narrow exception which is not expected to do violence to the strong Federal preemption scheme. *In agreeing to the Hawaii exception this body will be reaffirming the broad scope of ERISA preemption and the validity of the interpretation of the Federal courts in connection with the Hawaii statute.* To help allay the fears of those who might otherwise view this action as the beginning of a weakening of Federal preemption under ERISA, *the amendment contains an explicit statement that this limited exception shall not be considered a precedent with respect to extending similar treatment to any other State law.*

128 Cong. Rec. 30,356 (1982) (emphasis added).

The bill was then referred to the Conference Committee to reconcile the difference caused by the House amendment, which emphasized that the Hawaii exception would not serve as a precedent for other states. The Committee recommended the House version, which was then enacted into law.<sup>15</sup> 128 Cong. Rec. 33,183; 33,236; 33,240; 33,263; 33,433 (1982).

<sup>15</sup> The full text of the House amendment to the Hawaiian exception stated, "The amendment made by this section shall not be

The language and history of the PPSA totally undermine the Third Circuit's position in *Holliday*. In 1982, Congress adopted the Ninth Circuit's broad interpretation of the deemer clause, which insulates self-insured benefit plans from the laws of every state, except Hawaii. Pennsylvania and the other states of the Union remain governed by the interpretation of ERISA set forth in the Ninth Circuit's *Hewlett-Packard* and *Standard Oil of California* decisions. These Ninth Circuit opinions anticipated the language concerning self-insured plans in *Metropolitan Life*, 471 U.S. at 747, which the Third Circuit cavalierly dismissed as "dicta." The PPSA demonstrates that the Third Circuit's interpretation of the deemer clause was simply wrong.

## II. THE DECISIONS OF THIS COURT DEMONSTRATE THAT THE PENNSYLVANIA ANTI-SUBROGATION STATUTE DOES NOT FALL WITHIN THE "SAVINGS" CLAUSE FOR STATE INSURANCE LAW.

An integral part of the Third Circuit's ruling in *Holliday* was its preliminary determination that Pennsylvania's statutory ban on subrogation "regulates insurance" within the meaning of ERISA's "savings clause." *Holliday*, 885 F.2d at 85-86. This conclusion directly contradicts the subsequent holding of *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989), which found the "savings clause" inapplicable to state anti-subrogation laws. Drawing upon the "analysis under the McCarran-Ferguson Act," the Eighth Circuit distinguished subrogation from the "business of insurance," noting that:

The practice of subrogation does not transfer the risk from a policyholder to his or her insurer.

considered a precedent with respect to extending such amendment to any other State law." The amendment was eventually codified at § 301 of Pub. L. No. 97-473 and the notes to 29 U.S.C. § 1144.

Rather, it limits the recovery available to the policyholder by preventing a double recovery.

886 F.2d at 186.

Thus, *Baxter* and *Holliday* present the additional issue of whether a cost containment device which prevents "a double recovery" of employee benefits is subject to state law. Review of that issue by this Court would not only resolve a conflict among the Circuits,<sup>10</sup> but would also significantly expand the importance of this case. If state laws which govern subrogation and other cost containment innovations do not fall within the savings clause, then they are preempted with respect to *all* ERISA plans, both insured and non-insured. Consequently, a conclusive interpretation of the savings clause would be significant for virtually every ERISA plan in the nation.

The McCarran-Ferguson Act, 15 U.S.C. §§ 1101-015 *et seq.*, provides an exemption from the antitrust laws for the "business of insurance." The definition given to "business of insurance" in the McCarran-Ferguson Act is a major criterion for determining the meaning of "insurance" under the savings clause of ERISA. *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987). This Court's cases concerning the McCarran-

<sup>10</sup> Actually, the cases which concern the relationship of the savings and deemer clauses with respect to subrogation are chaotic. In *Holliday*, the Third Circuit held that state laws in this area survive preemption under both clauses while, in *Baxter*, the Eighth Circuit held that these laws fail under both clauses. A third view holds that state anti-subrogation laws survive preemption under the savings clause but, with respect to self-insured funds, fail under the deemer clause. *E.g.*, *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust Fund v. Pagyca*, 801 F.2d 1157, 1160-62 (5th Cir. 1986).

Hence, depending upon the Circuit, state laws regulating subrogation may be: (1) preempted for all ERISA plans, (2) enforceable with respect to all plans, or (3) preempted for self-insured ERISA plans and binding upon insured plans.

Ferguson exemption demonstrate that subrogation laws cannot be equated with "insurance" laws.

In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), a group of pharmacists sued an insurance company, Blue Shield, under the antitrust laws. Blue Shield had negotiated agreements with pharmacists throughout Texas. These agreements required participating pharmacists to give Blue Shield a substantial discount. The plaintiffs alleged that the practice amounted to price-fixing and a group boycott. Blue Shield countered that the discount practice was part of the "business of insurance" and, thus, exempt under McCarran-Ferguson. This Court disagreed with Blue Shield, noting that "[t]he primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk." According to *Royal Drug*:

The Pharmacy Agreements . . . do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by Blue Shield. By agreeing with pharmacies on the maximum prices it will pay for drugs, *Blue Shield effectively reduces the total amount it must pay to its policyholders*. The Agreements thus enable Blue Cross to minimize costs and maximize profits. Such cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."

440 U.S. at 214 (emphasis added).

*Royal Drug* was reaffirmed in *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982), where an insurance company employed a utilization review committee of chiropractors to determine whether chiropractic bills submitted by insureds were excessive. When the plaintiff, a chiropractor, challenged the practice under the antitrust laws, the respondent invoked the McCarran-Ferguson exemption for "the business of insurance."

Citing *Royal Drug*, this Court found the exemption inapplicable.

*Royal Drug* and *Pireno* stand for the proposition that "cost-savings arrangements" designed to minimize the expenditure necessary to provide certain benefits are not the "business of insurance." Hence, while cost containment measures may be challenged under the federal anti-trust laws (if any such challenge has merit), ERISA insulates them from attack under state law. The Third Circuit would give cost containment the worst of all worlds, denying favorable treatment under either McCarran-Ferguson or ERISA. That result would controvert the will of Congress, flout the precedents of this Court, and, in view of the importance of sound cost containment to the health care system, disserve the interests of all American workers and their families.

#### CONCLUSION

For the foregoing reasons, FMC Corporation's petition for a writ of *certiorari* should be granted.

Respectfully submitted,

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IN THE

**Supreme Court of the United States**

OCTOBER TERM, 1989

**FMC CORPORATION,**

*Petitioner,*

v.

**CYNTHIA ANN HOLLIDAY,**

*Respondent.*

**On Petition for Writ of Certiorari to the  
United States Court of Appeals for the Third Circuit**

**BRIEF OF THE CENTRAL STATES, SOUTHEAST AND  
SOUTHWEST AREAS HEALTH AND WELFARE FUND AS  
AN AMICUS CURIAE IN SUPPORT OF PETITIONER**

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BRIEF OF THE CENTRAL STATES, SOUTHEAST AND  
SOUTHWEST AREAS HEALTH AND WELFARE FUND AS  
AN *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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## THE INTEREST OF THE AMICUS CURIAE

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The Central States, Southeast and Southwest Areas Health and Welfare Fund ("Fund") is a Taft-Hartley trust and an employee welfare benefit plan as described in Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1002(1).<sup>1</sup> See *Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 561-562 (1985). The Fund self-funds all medical, hospital and disability benefits that it provides to its more than 500,000 participants and beneficiaries. These participants and beneficiaries reside in over thirty-four states.

In compliance with their fiduciary duties under ERISA to manage plan assets prudently and in the best interest of all participants and beneficiaries, the Trustees of the Fund have included cost-containment measures in the plan, such as subrogation and coordination of benefits. See 29 U.S.C. §1104(a)(1)(B). Because of escalating medical costs, these cost-containment measures are necessary to preserve plan assets for the payment of current and future medical benefits and to eliminate duplication of benefits with other insurance or plan coverages.

Multiemployer benefit plans are particularly affected by substantial increases in medical care costs because their income is primarily, if not solely, from employer contributions. The amount of each employer's contribution is fixed by collective bargaining agreements negotiated by the

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<sup>1</sup> Both the petitioner, FMC Corporation, and the respondent, Cynthia Ann Holiday, gave the Fund consent to file this *amicus curiae* brief, and copies of their attorneys' letters confirming this consent have been sent with this brief to the Clerk of the United States Supreme Court.

union and employers every three to five years. If the employers' contributions are not sufficient to fund plan benefits, the trustees of such plans have limited choices, namely to reduce benefit levels and/or to institute cost-containment measures.

The Fund is significantly and adversely affected by the ruling in this case by the United States Court of Appeals for the Third Circuit because the Fund does provide benefits to participants and beneficiaries who reside in Pennsylvania. Due to the Third Circuit's opinion in this case, the Fund probably will not be able to enforce its subrogation provision in Pennsylvania and thus will be deprived of an important cost-containment measure. Moreover, the Fund will have to adopt different administrative procedures to comply with this Pennsylvania insurance law, thereby causing the Fund to incur another financial cost and administrative burden.

If this decision were limited to one state and one insurance law, the financial and administrative burden on multi-state employee benefit plans such as the Fund would not be so threatening. However, this disregard of the scope of ERISA preemption is not so limited and, in fact, is increasing. In this case, the Third Circuit relied considerably upon the reasoning and ruling of the United States Court of Appeals for the Sixth Circuit in the case of *Northern Group Services, Inc. v. Auto Owners Ins., Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, \_\_\_ U.S. \_\_\_, 108 S.Ct. 1754 (1988). In *Northern Group*, the Sixth Circuit held that a Michigan no-fault insurance statute, which authorized motor vehicle insurance companies and their insureds to subordinate motor vehicle no-fault benefits to benefits provided by self-funded employee welfare benefit plans in violation of the coordination of benefits terms of those plans, was not preempted by ERISA because of the priority of the state's power to regulate insurance. 833

F.2d at 94-95. To justify this holding, the Sixth Circuit devised a new test for ERISA preemption, requiring that if a self-funded employee benefit plan is to avoid state regulation, it must first demonstrate a federal interest in national uniformity *independent of and beyond* the requirements of Section 514 of ERISA, and that this specific federal interest must then "... outweigh the McCarran-Ferguson interest in state regulation of insurance." *Id.* at 95.

Thus, there are currently two Circuits which have issued decisions which undermine both ERISA preemption and the efforts of employee welfare benefit plans to contain costs so as to be able to provide benefits at established benefit levels. As a result of the *Northern Group* case, employee welfare benefit plans operating in Michigan have initiated or been named as parties in expensive litigation concerning whether their coordination provisions are enforceable.<sup>2</sup> Now that the Third Circuit has advanced a different but equally vague and unsupportable test for ERISA preemption, employee benefit plans can expect to be involved in another flood of litigation. In the meantime, multi-state plans which provide benefits in Pennsylvania will incur the financial and administrative costs of having to comply with the Pennsylvania prohibition against subrogation.

<sup>2</sup> Only some of the many post-*Northern Group* cases are listed below: *Auto Club Ins. Assc. v. Frederick & Herrud, Inc.*, 433 Mich. 900 (1989), petition for cert. filed, *Thorn Apple Valley, Inc. v. Auto Club Ins. Assc.*, \_\_\_ U.S.L.W. \_\_\_ (U.S. Dec. 29, 1989) (No. 89-1125); *Central States, Southeast and Southwest Areas Health and Welfare Fund v. Hawkeye-Security Ins. Co.*, \_\_\_ U.S. \_\_\_, 109 S.Ct. 783 (1989); *Winstead v. Indiana Ins. Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, \_\_\_ U.S. \_\_\_, 109 S.Ct. 839 (1989); *Liberty Mutual Ins. Co. v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384, *reh'g denied*, \_\_\_ F.2d \_\_\_ (6th Cir. 1989). Indeed, the *Northern Group* case came before the Sixth Circuit again for oral argument on January 25, 1990.



Perhaps the most threatening aspect of this increasing disregard for the wide scope of ERISA preemption is the signal that these decisions send to the states and insurance lobbyists. By requiring employee benefit plans to comply with state insurance laws which shift a substantial financial burden from for-profit insurance companies to employee benefit plans, the courts are encouraging the states to enforce and enact similar insurance laws against such plans.

If this trend continues, many employee benefit plans will have to reduce substantially their benefit levels. The administrative nightmare and the substantial financial problems caused by a patchwork scheme of federal and state regulation of multi-state employee benefit plans foretold by this Court is thus becoming a reality. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 107-108 (1983); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9-11 (1987). Accordingly, the Fund urges this Court to issue a writ of *certiorari* in this case and stem the tide of case law that will prove to be a financial blow to the millions of participants and beneficiaries of self-funded employee benefit plans.

## SUMMARY OF THE ARGUMENT

---

The Fund urges this Court to issue a writ of *certiorari* and to reverse the holding of the United States Court of Appeals for the Third Circuit in this case for several reasons. First, the Third Circuit's interpretation of the deemer clause of Section 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§1001, 1144(b)(2)(B), directly conflicts with the plain meaning and legislative history of Section 514 and with several of this Court's decisions. By devising a new test for ERISA pre-

emption which states that the deemer clause allows preemption of state insurance law only where the state law conflicts with a "core ERISA concern," the Third Circuit is undermining the clear and expressed purpose and intent of Congress in including a broad preemption provision in ERISA which was to prevent patchwork regulation of self-funded employee benefit plans by the states. Moreover, the Third Circuit's holding directly conflicts with the decisions of this Court in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). Contrary to the Third Circuit's ruling, this Court in *Shaw* held that ERISA preemption is not limited to state laws that deal only with the subject matters covered by ERISA. 463 U.S. at 98. Moreover, the Third Circuit's holding violates the distinction mandated by Congress and recognized by this Court in the *Metropolitan Life* case, wherein this Court stated that insured employee benefit plans are subject to indirect state regulation while self-funded plans are not. 471 U.S. at 747.

A writ of *certiorari* should also be granted because the decision of the Third Circuit further splits the United States Courts of Appeal on the issue of the scope of ERISA preemption for self-funded employee benefit plans. Both the Third Circuit in this case and the Sixth Circuit in the case of *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, \_\_\_ U.S. \_\_\_, 108 S.Ct. 1754 (1988), have advanced different but equally vague and unsupportable tests for ERISA preemption. The Third and Sixth Circuits' restrictive interpretations of Section 514 conflict with the interpretations given by the Eighth, Seventh, Ninth, Fourth and Fifth Circuits.

This conflict among the Circuits presents serious public policy problems. The decisions of the Third and Sixth Cir-

cuits prohibit self-funded employee benefit plans from enforcing plan cost-containment measures that are critical to such plans. As a result of escalating medical care costs and the limited financial resources of such plans, many such plans have adopted subrogation and coordination of benefits provisions as cost-containment measures. If such plans are prohibited from utilizing these cost-containment measures, comparable reductions in benefit levels will have to occur.

Moreover, this split among the Circuits has caused, and will continue to cause, wide-spread litigation which employee benefit plans can little afford. If the precedents set by the Third and Sixth Circuits are followed, multi-state employee benefit plans will incur the substantial and potentially crippling administrative and financial costs of having to adopt separate plans and administrative procedures for each state in which their participants and beneficiaries reside.

## REASONS FOR GRANTING THE WRIT

### I.

#### REVIEW IS NECESSARY TO RESOLVE THE CONFLICT BETWEEN THE DECISIONS OF THIS COURT AND THAT OF THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT WHICH DECISION SEVERELY LIMITS THE SCOPE OF ERISA PREEMPTION OF STATE LAW REGULATION OF SELF-FUNDED EMPLOYEE BENEFIT PLANS.

The Third Circuit's decision in the instant case directly conflicts with the plain meaning and legislative history of Section 514 of ERISA and with several of this Court's decisions which construe Section 514 of ERISA. In the instant case, the Third Circuit devised a new test for

ERISA preemption, allowing preemption of a state insurance law only where the state law conflicts with a "core ERISA concern." *FMC Corp. v. Holliday*, 885 F.2d 79, 86, 89-90, *reh'g denied*, \_\_\_\_ F.2d \_\_\_\_ (3rd Cir. 1989). To justify adoption of this "core conflict test," which subordinates Congress' goal to establish uniform, comprehensive federal regulation of employee benefit plans to the states' power to regulate insurance, the Third Circuit advances an unsupportable interpretation of the deemer cause in Section 514, selectively cites legislative history out of context and criticizes a prior ruling by this Court, as lacking statutory and legislative history foundation, concerning the distinction drawn between preemption as applied to self-funded employee benefit plans and insured employee benefit plans. *Id.* at 86-89. The Third Circuit's decision also constitutes a direct conflict with this Court's holding that ERISA preemption is not limited to state laws that deal with the subject matters covered by ERISA. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 98.

Without identifying an ambiguity in the deemer clause, the Third Circuit engages in a selective review and strained analysis of the legislative history underlying the deemer clause to determine its scope. The Third Circuit then concludes that "... the deemer clause guards against any insurance regulation that infringes on such ERISA areas as reporting, disclosure and non-forfeitability." *FMC Corp. v. Holliday*, 885 F.2d 79, 88, *reh'g denied*, \_\_\_\_ F.2d \_\_\_\_ (3rd Cir. 1989).

The Third Circuit's analysis and conclusion are erroneous for several reasons. First, this Court has held that the plain meaning of the deemer clause is unambiguous: "The deemer clause makes clear that a state law that 'purport[s] to regulate insurance' cannot deem an employee benefit plan to be an insurance company." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987). Thus,



the deemer clause is the specified exception to the savings clause, which preserves state insurance and other laws from ERISA preemption, and the deemer clause prohibits employee benefit plans from being regulated by "... any law of any State purporting to regulate insurance companies, insurance contracts. ..." 29 U.S.C. §1144(b)(2)(B). See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 733 (1985). Moreover, this Court has emphasized that, in construing Section 514 of ERISA, the plain language must be enforced unless there is a good reason to believe Congress intended a more restrictive meaning to apply. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 97. Therefore, the Third Circuit's narrow construction of the deemer clause is in conflict with principles this Court has recognized and expressed.

The Third Circuit's analysis of the deemer clause also fails due to its highly selective and biased review of the legislative history underlying Section 514 of ERISA. In examining the legislative history, the Third Circuit argues that preemption under the deemer clause is basically limited to state laws that constitute "... back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation." 885 F.2d at 86, cited in, *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 91-94 (6th Cir. 1987), cert. denied, \_\_\_ U.S. \_\_\_, 108 S.Ct. 1754 (1988). To support this argument, the Third Circuit selectively quotes comments of ERISA legislative sponsors which relate only to their concern with state laws being "hastily contrived" to regulate ERISA plans. However, the very quotations utilized by the Third Circuit serve to underscore Congress' primary concern in including a broad preemption provision in ERISA, which was that employee benefit plans be subject to uniform federal regulation. The Senator Javits quotation, that ERISA preemption extended to "[s]tate laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected

to the Federal regulatory scheme,' " clearly expresses his concern with the states' passing laws after ERISA's enactment to regulate areas of plan administration and operation not specifically governed by ERISA. 885 F.2d at 87. Senator Williams' statement also stressed Congress' concern that state professional regulations "... should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized." *Id.*

Uniform federal regulation of employee welfare and pension benefit plans was one of the fundamental and overriding purposes of Congress in enacting ERISA. So as to remove any doubt concerning the purposes that ERISA was to serve, Congress set forth its findings and declaration of policy in Section 2 of ERISA, which, in part, provides:

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations;

\* \* \* \* \*

29 U.S.C. §1001(a).

Moreover, ERISA's legislative sponsors stressed the importance of uniform federal regulation of employee benefit plans. In quoting Senator Williams, the Third Circuit ignores his explanation of the scope of ERISA preemption:

It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforce-



ment provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

*Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 99, quoting 120 Cong. Rec. 29933. The Third Circuit also selectively edits Senator Javits' remarks, which continued after the statement quoted by the Third Circuit: "Although the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs." *Id.* at 99-100 n.20. As to the task force report denigrated by the Third Circuit, it was Senator Javits who explained that the members of the conference responsible for the final draft of ERISA had assigned the Congressional Pension Task Force with the responsibility of studying and evaluating ERISA preemption to determine what modifications in preemption policy would be necessary. *Id.* Another ERISA sponsor, Representative Dent, who was not quoted by the Third Circuit, also stressed the breadth of ERISA preemption:

Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

*Id.* at 99.

Based upon a thorough and unbiased examination of the legislative history underlying Section 514 of ERISA, this Court has repeatedly held that ERISA preemption cannot be limited to only those state laws which regulate the matters covered by ERISA, including reporting, disclosure and fiduciary responsibility. *Id.* at 98. On the contrary, this Court has held that Section 514 was intended "... to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA's substantive requirements." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 739. In fact, Congress considered and rejected bills which allowed preemption of only subject matters expressly governed by ERISA and which did not include a deemer clause reserving regulation of ERISA plans to the federal government. 463 U.S. at 98; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 46. These bills were rejected not only because they would have required ERISA plans to comply with multiple and potentially conflicting state laws, but also because they raise the possibility of "endless litigation" on issues of whether state regulation impinged upon federal regulation. 463 U.S. at 99 n.20. Moreover, after a period of monitoring by the Congressional Pension Task Force and hearings by a House Subcommittee, a report evaluating ERISA's preemption provisions was issued, and it stated that: "the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded." *Id.* at 100 n.20, quoting H.R. Rep. No. 94-1785, p. 47 (1977).

Despite this overwhelming authority supporting the wide scope of ERISA preemption, the Third Circuit further contends that any interpretation of the deemer clause other than that it prohibits insurance regulation of the "central aspects of ERISA" would render the savings clause meaningless or read in distinctions that are not sup-

ported by the statute. 885 F.2d at 88. Although the Third Circuit does not explain how any other interpretation of the deemer clause would "swallow" the savings clause, it criticizes this Court's interpretation of the savings and deemer clauses in the *Metropolitan Life* case, wherein this Court stated that insured plans are subject to indirect state regulation while self-funded employee benefit plans are not. *Id.* at 89. The Third Circuit implies that this Court erroneously created this distinction between self-funded and insured plans without reliance upon statutory language or legislative history, but instead based this distinction upon the "vague language in Congress' *post-hoc* study." *Id.*

Again, the Third Circuit chooses to ignore the statutory language and legislative history of Section 514 of ERISA. The deemer clause prevents an employee benefit plan from being deemed an insurance company or other insurer or as being engaged in the business of insurance "... for purposes of any law of any State purporting to regulate insurance companies, insurance contracts. . . ." 29 U.S.C. §1144(b)(2)(B). However, the deemer clause does not preempt state laws regulating insurance contracts purchased by an employee benefit plan. The regulation of the content of insurance contracts is not subject to preemption due to the plain meaning of the savings clause. Thus, if an employee benefit plan chooses to self-fund its benefits, it cannot be deemed an insurance company which under the laws of most, if not all, states must submit its benefit plan containing provisions concerning eligibility, benefit levels and terms and conditions for receiving benefits to the state department of insurance for review and approval as to its compliance with the state insurance code and other regulations. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 727-728. On the other hand, those plans which decide to purchase insurance coverage

for their members from insurance companies must comply with the state law limitations placed on those insurance contracts. This indirect regulation of insured plans is thus expressly sanctioned by Congress. Moreover, the fact that plans may choose to self-fund benefits, and thus be entitled to adopt benefit rules without regard to state law, or to purchase insurance policies subject to state law restrictions comports with both the statutory provisions of ERISA's entrusting plan fiduciaries with exclusive authority to manage and control plan assets and with the legislative history which establishes that plan fiduciaries have broad discretion in determining how the plan is to be administered. See 29 U.S.C. §§1102(a)(1), 1103(a).

The Third Circuit argues in the alternative that its proposed test concerning the application of the deemer clause would not eradicate the distinction drawn by this Court between insured and self-funded employee benefit plans. 885 F.2d at 89. The Third Circuit explains that "... under *Metropolitan Life* insured plans would *per se* survive the deemer clause, while self-insured plans would merely be considered on a case-by-case basis as to whether the state regulation involved affects a central concern of ERISA." *Id.*

The Third Circuit's contention that its proposed test is actually in compliance with this Court's guidelines in *Metropolitan Life* lacks merit. The Third Circuit has failed to identify any statutory, legislative history or Supreme Court case law authority for redrafting the deemer clause so as to limit preemption to those state laws which affect a "central concern" of ERISA. Furthermore, the Third Circuit does not define what constitutes a "central concern" of ERISA. Acknowledging the vagueness of its test, the Third Circuit admits that ERISA preemption of state law as applied to self-funded employee benefit plans will have to be decided on a case-by-case basis.



Because the Third Circuit rejects uniformity of regulation of employee benefit plans as a "central concern" of ERISA, it is apparent that the Third Circuit is suggesting a highly restrictive definition of "central concern" of ERISA. Thus under the Third Circuit's test, multi-state plans which, as this Court has recognized, already have the task of coordinating complex administrative activities will also have to endure the considerable inefficiencies, administrative burdens and financial costs of complying with a patchwork scheme of regulation. See *Fort Halifax Packing Co. v. Coyne*, 482 U.S. at 11. Such a result cannot be allowed to stand under the plain meaning and legislative history of Section 514 and the decisions of this Court.

## II.

### REVIEW IS NECESSARY TO RESOLVE THE CONFLICT BETWEEN THE UNITED STATES COURTS OF APPEAL ON THE SCOPE OF ERISA PREEMPTION AS APPLIED TO SELF-FUNDED EMPLOYEE BENEFIT PLANS.

In the petition of FMC Corporation for writ of *certiorari*, the conflicts among the circuits concerning the issue of the scope of ERISA preemption as to self-funded employee benefit plans is thoroughly discussed. To avoid repetition, the Fund hereby adopts FMC's arguments. The Fund, however, will discuss the adverse public policy consequences that will result unless this split among the circuits is promptly resolved.

The problem of rising medical care costs for self-funded employee benefit plans cannot be overstated. For every year since 1965, inflation in medical care prices has been higher than the general rate of inflation for the economy on a whole.<sup>3</sup> In 1987, the price of health care in this coun-

<sup>3</sup> Sharkey & Buckle, *The Medicare Prospective Payment System: Impact On The Frail Elderly And An Alternative Reimbursement Formula*, 3 Notre Dame J. of L., Ethics & Pub. Pol'y 227, 228 (1988).

try exceeded \$500 billion, increasing 9.8 percent from 1986.<sup>4</sup> In 1988, total health care expenditures rose 10.2 percent from 1987 to an estimated \$558.7 billion or about \$2,200.00 per capita.<sup>5</sup> Total health care expenditures for 1989 are expected to rise to approximately \$618.4 billion.<sup>6</sup> If health care trends continue, medical care costs could triple to \$1.5 trillion by the year 2000.<sup>7</sup>

In 1988, employers with insured programs experienced an average increase in health plan costs of 13.7 percent; whereas, self-funded plans experienced an average increase of 24.8 percent in health plan costs for 1988.<sup>8</sup> In one survey of 2,000 employers who either purchased insurance coverage or self-funded health benefits, total health care costs equaled 37.2 percent of those employers' profits.<sup>9</sup>

As a result of these substantial and escalating costs of providing medical care, employee benefit plans throughout the country have had to reduce benefits, institute cost-containment measures, establish cost-management programs or a combination of the above. Although most of these measures involve a transfer of costs to the participants and beneficiaries or a restriction in the type or

<sup>4</sup> Letsch, Levit & Waldo, *National Health Expenditures, 1987*, 10 Health Care Fin. Rev. 109 (Winter 1988).

<sup>5</sup> Francis, *U.S. Industrial Outlook 1989: Health Services*, Med. Benefits, Feb. 15, 1989, at 1.

<sup>6</sup> *Id.* at 2.

<sup>7</sup> *Costs Will Rise into the 1990s, Pushing Up Corporations' Benefits Costs*, 16 Pens. Rep.(BNA) 1979 (November 20, 1989).

<sup>8</sup> A. Foster Higgins & Co., *Health Care Benefits Survey, 1988*, Med. Benefits, Feb. 28, 1989, at 1. See also, *Average Costs Rose 18.6 Percent Under Employer Plans, Survey Finds*, 16 Pens. Rep. (BNA) 250 (Feb. 13, 1989). This survey covered 1,600 employers and 10 million employees and dependents.

<sup>9</sup> DiBlase, *Group Health Bills Equal A Third Of Profits*, Bus. Ins., May 29, 1989, at 1.



length of medical care, two cost-containment measures, subrogation and coordination of benefits, do not. On the contrary, subrogation and coordination of benefits provisions prevent the duplication of benefits by the plan where other coverage exists and covers the particular injury or illness. Subrogation and coordination provisions also ensure that primary responsibility for providing benefits for specific risk injuries is not transferred from specific risk insurers, such as motor vehicle insurers, to employee benefit plans.

The Fund's Plan Document provides for subrogation against any person or entity responsible for providing a recovery to a Fund participant or beneficiary for injuries sustained as a result of an accident or illness. The Fund's coordination provision provides that where no-fault or personal injury protection ("PIP") motor vehicle insurance coverage exists, the no-fault or PIP coverage shall be primarily responsible for providing benefits to a mutually covered beneficiary who has sustained injuries as a result of a motor vehicle accident and the Fund shall provide excess coverage.

The Fund's Trustees included these subrogation and coordination provisions in compliance with their fiduciary duties to manage the plan assets "... solely in the interest of the participants and beneficiaries ..." and, in managing these assets, to exercise "... the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." 29 U.S.C. §1104(a)(1)(B). These subrogation and coordination provisions provide substantial cost-savings to the Fund, allowing it to cover rising medical costs without having to enact comparable benefit cuts or restrictions.

The application of state laws to prohibit the Fund from enforcing its subrogation and coordination provisions deprives the Fund of very valuable and necessary cost-containment measures. As a result, the Trustees are limited primarily to changes in the benefit plan design that transfer the costs of rising medical care to the Fund's participants and beneficiaries or restrict their medical care options.

State laws such as Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law and Section 500.3109a of the Michigan No-Fault Insurance Act effectively usurp the Trustees' exclusive authority and responsibility under ERISA to control and manage plan assets in the best interest of all participants and beneficiaries. See 29 U.S.C. §1102(a)(1) (the plan must be administered pursuant to a written instrument and named plan fiduciaries have authority "... to control and manage the operation and administration of the plan."); 29 U.S.C. §1103(a) ("... the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan ..." except for certain circumstances not applicable to this case); 29 U.S.C. §1104(a)(1)(D) (plan fiduciaries are required to perform their duties solely in the interest of all participants and beneficiaries in accordance with the provisions of the plan document).

There are a substantial number of state laws either prohibiting or restricting subrogation and coordination in the contexts where the Fund utilizes these cost-containment measures. See, e.g., *Baxter v. Lynn*, 886 F.2d 182, 185 *reh'g denied*, \_\_\_ F.2d \_\_\_ (8th Cir. 1989) (Missouri common law limitation on subrogation); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) (Arizona anti-subrogation law); *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987),

*cert. denied*, \_\_\_\_ U.S. \_\_\_\_, 108 S.Ct. 1754 (1988) (Michigan statute making all health coverages primarily responsible and making no-fault motor vehicle coverages secondarily responsible for benefits concerning injuries sustained in motor vehicle accidents); *Hunt v. Sherman*, 345 N.W.2d 750 (Minn. 1984) (Minnesota common law restriction on subrogation). If the decision in this case is allowed to stand, there is little doubt that states with such laws will increasingly attempt to enforce them and other states will consider adopting similar laws.

The proverbial floodgates of litigation, which have already been opened by the vague and differing preemption tests adopted by the Third and Sixth Circuits, will be pushed further open. Thus, employee benefit plans, which are struggling to meet increasing medical costs, will have to expend considerable plan assets on expensive litigation in states throughout the nation. Moreover, these plans cannot avoid this litigation because, *inter alia*, they cannot afford to eliminate these cost-containment measures and they cannot afford to administer a different plan in each state in which they operate. Thus, the nightmare of patchwork regulation of employee benefit plans by the states, which Congress intended to avoid by enacting Section 514 of ERISA, is becoming a reality.

## CONCLUSION

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For the reasons discussed herein, this Court should grant the petition for writ of *certiorari* filed by FMC Corporation to resolve the conflict between this Court's interpretation of Section 514 of ERISA and that of the

Third Circuit, to reconcile the conflicts between the Courts of Appeal and to forestall the future adverse effects of state insurance laws' being applied to self-funded employee benefit plans.

Respectfully submitted,

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Dated: February 1, 1990

No. 89-1048

FILED

APR 20 1990

JOSEPH E. SPANIOLO, JR.  
CLERK

In The  
Supreme Court of the United States

October Term, 1989

—◆—  
FMC CORPORATION

*Petitioner,*

vs.

CYNTHIA ANN HOLLIDAY

*Respondent.*

—◆—  
On Writ Of Certiorari To The United States  
Court Of Appeals For The Third Circuit

—◆—  
JOINT APPENDIX  
—◆—

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PETITION FOR CERTIORARI  
FILED DECEMBER 29, 1989  
CERTIORARI GRANTED FEBRUARY 20, 1990



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The following opinions, judgments and orders may be found in the Appendix to the Petition for Writ of Certiorari:

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## RELEVANT DOCKET ENTRIES

In the United States District Court for the Western District of Pennsylvania:

May 16, 1988	Complaint and summons issued.
July 21, 1988	Answer and Affirmative Defenses by Defendant with Jury Demand.
December 2, 1988	Motion for Summary Judgment with Proposed Order by Plaintiff.
December 5, 1988	Motion for Summary Judgment with Proposed Order by Defendant.
December 9, 1988	Pretrial Statement by Plaintiff.
January 6, 1989	Pretrial Statement by Defendant.
January 9, 1989	Response in Opposition to Motion by Defendant for Summary Judgment by Plaintiff.
March 14, 1989	Memorandum Opinion (Bloch, J.).
March 14, 1989	Judgment Order dated 3/14/89 that Plaintiff's Motion for Summary Judgment is Denied, Defendant's Motion for Summary Judgment is Granted.
March 29, 1989	Notice of Appeal from Order dated 3/14/89.

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In the United States Court of Appeals for the Third Circuit:

September 11, 1989	Opinion and Judgment issued.
September 22, 1989	Petition for Rehearing filed.
October 5, 1989	Petition for Rehearing denied.
December 29, 1989	Petition for Writ of Certiorari filed.
February 20, 1990	Petition for Writ of Certiorari granted.

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IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC Corporation,	)	
a corporation	)	
Plaintiff,	)	
v.	)	Civil
Cynthia Ann Holliday,	)	Action No.
an individual,	)	
Defendant.	)	

COMPLAINT

Plaintiff, FMC Corporation ("Plaintiff" or "FMC") by its attorneys, Kirkpatrick & Lockhart, files this complaint seeking a declaratory judgment pursuant to 28 U.S.C. § 2201. In support of its claims, FMC avers as follows:

PARTIES

1. FMC Corporation is a corporation organized and existing under the laws of Delaware and having its principal place of business at 2000 E. Randolph Drive, Chicago, Illinois 60601.

2. Cynthia Ann Holliday ("Ms. Holliday"), is an individual residing at 1569 Church Street, Indiana, Pennsylvania 15701.

JURISDICTION AND VENUE

3. Jurisdiction over this action is based on 28 U.S.C. § 1332 granting district courts jurisdiction over civil actions where the parties are citizens of different states and



where the amount in controversy exceeds \$10,000, exclusive of interest and costs. There is complete diversity of citizenship between FMC and Ms. Holliday and the amount in controversy exceeds \$10,000, exclusive of interest and costs. Jurisdiction is also based on 28 U.S.C. § 2201 providing for declaratory judgments. FMC's cause of action and its request for declaratory judgment arise under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*

4. Venue is proper in this court pursuant to 28 U.S.C. § 1391 because the defendant resides, and the claim involved in this matter arose, in this district.

#### FACTUAL BACKGROUND

5. At all times relevant to this matter Gerald S. Holliday, the father and legal guardian of Ms. Holliday, has been employed by FMC. Mr. Holliday, during his employment, has subscribed to the FMC Salaried Health Care Plan ("Health Plan").

6. FMC is the fiduciary of the Health Plan for purposes of 29 U.S.C. § 502(a)(3) of ERISA and is, as a result, a proper party to bring this action. 29 U.S.C. § 1132(a)(3).

7. The Health Plan is filed with the U.S. Department of Labor under Plan No. PN540. The Health Plan is self-funded. (A copy of the Health Plan is attached hereto as Exhibit A.).

8. The Health Plan is an employee welfare benefit plan within the meaning of 29 U.S.C. § 3 of ERISA since it was established and is maintained by FMC, an employer, to provide to beneficiaries medical, surgical and hospital

care benefits in the event of sickness, accident or disability. 29 U.S.C. § 1002.

9. The Health Plan, in addition to providing benefits for FMC employees, also provides health care coverage for the dependents of FMC employees. Those dependents include unmarried children less than 19 years old who reside in the household of the FMC employee. Ms. Holliday at all times relevant hereto was a dependent of Gerald Holliday, and therefore eligible for coverage under the Health Plan.

10. Ms. Holliday was injured in an automobile accident in White Township, Indiana County, Pennsylvania on January 16, 1987. She was the passenger in a car driven by Robert Scott Lyons, a minor residing in Indiana County, Pennsylvania. Lyons lost control of the vehicle he was operating, crossed the line of the roadway and collided head-on with a vehicle coming in the opposite direction.

11. As a result of the accident, Ms. Holliday, who was then 15, suffered severe injuries including a collapsed lung, severe head lacerations and a depressed skull fracture.

12. Since the date of the accident, Ms. Holliday has required intensive and extensive medical care and has incurred medical costs in excess of \$105,000.

13. The Health Plan has provided approximately \$105,000 in benefits to cover the medical expenses incurred by Ms. Holliday.

14. On April 20, 1987, Gerald Holliday, on behalf of Ms. Holliday, commenced in the Court of Common Pleas

for Indiana County, Pennsylvania, a civil action (the "Indiana County action") against Robert Scott Lyons, the driver of the vehicle in which his dependent was riding at the time of her serious injury. The complaint in that action (a copy of which is attached hereto as Exhibit B) alleges that the defendant, Lyons, was negligent in his operation of the vehicle in which Ms. Holliday was a passenger.

15. The Health Plan provides that claims paid pursuant to the Plan are subject to subrogation. In accordance with that provision, FMC contacted in or about October 1987 Thomas G. Johnson ("Johnson"), the attorney representing Ms. Holliday in the Indiana County action referred to herein. FMC informed Johnson that it expected to exercise its subrogation rights with regard to any award received by Ms. Holliday in connection with the Indiana County action.

16. FMC, in its capacity as the fiduciary of the Health Plan, had a responsibility to make this contact in connection with the orderly administration of the Health Plan and in accordance with the ERISA law and the public policy behind it which promote the establishment and maintenance of employee benefit plans.

17. Johnson informed FMC at that time that he would not accede to FMC's exercise of its subrogation rights, stating that under the Pennsylvania Motor Vehicle Financial Responsibility Act of 1984 (the "Act"), 75 Pa.C.S.A. §§ 1701 *et seq.*, medical providers such as FMC were prohibited from exercising subrogation rights with respect to an award received by an injured party as a

result of an automobile accident. Despite numerous attempts by FMC to dissuade Johnson of the validity of this position, Johnson, on behalf of Ms. Holliday, has clung to the position that the Act, at § 1720 relating to subrogation, precludes FMC from exercising its subrogation rights.

### COUNT I

#### The Employee Retirement Income Security Act Preempts the Application of the Subrogation Section of the Pennsylvania Motor Vehicle Financial Responsibility Act of 1984

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18. The averments of paragraphs 1 through 17 are incorporated by reference as though set forth at length herein.

19. Despite repeated demands, Johnson, on behalf of Ms. Holliday, has refused to accede to FMC's rightful exercise of its subrogation rights. Johnson in taking this position has relied on § 1720 of the Act relating to subrogation. That section provides:

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under § 1711 (relating to required benefits), § 1712 (relating to availability of benefits) or § 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under § 1719 (relating to coordination of benefits).

20. The ERISA statute at 29 U.S.C. § 514(a) contains a broad preemption clause which states that "the statute shall supersede any and all state laws insofar as they may

now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

21. The ERISA statute at § 514(b)(2)(A) also contains an insurance savings clause which broadly states that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A).

22. However, a single exemption to the "savings clause" is found in § 514(b)(2)(B), the so-called "deemer clause," which states that no employee benefit plan "shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies or investment companies." 29 U.S.C. § 1144(b)(2)(B).

23. The "savings clause" and the "deemer clause" of the ERISA statute, when read together, represent Congress' intent to preempt any state law which attempts or purports to regulate a self-insured medical plan.

24. The Health Plan is such a self-insured plan.

WHEREFORE, in light of the fiduciary's responsibility under ERISA to enforce the provisions of an employee benefit plan, FMC respectfully requests that this court enter judgment in favor of FMC as follows:

(a) declaring that ERISA preempts the subrogation section of the Act (75 Pa.C.S.A. § 1720) as it applies to a self-insured plan, such as FMC's Health Plan;

(b) declaring that FMC, as a result, may exercise its subrogation rights;

(c) directing Johnson, on behalf of Ms. Holliday, to cooperate with and otherwise facilitate FMC's exercise of its subrogation rights; and

(d) granting such further relief as this court deems just and proper, including FMC's costs and attorneys' fees.

## COUNT II

### The Act's Subrogation Section is Not Meant to Reach Medical Providers Such as FMC

25. The averments of paragraphs 1 through 24 are incorporated by reference as though set forth at length herein.

26. The Act at § 1720, relating to subrogation, provides that there shall be no subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits or benefits available under § 1711, § 1712, § 1715 or § 1719. (A copy of Subchapter B of the Act, in which these provisions appear, is attached hereto as Exhibit C.)

27. Sections 1711, 1712, and 1715 of the Act specifically limit their coverage to policies provided by an insurer issuing or delivering liability insurance policies covering any motor vehicle of the type required to be registered under the Act. At § 1702, the Act defines insurer or insurance company as a motor vehicle liability insurer subject to the requirements of the Act. (A copy of § 1702 is attached hereto as Exhibit D.)



28. Section 1719 of the Act relates to the coordination of benefits, stating that except for worker's compensation, a policy of insurance issued or delivered pursuant to Subchapter B shall be primary. The Section adds that any program, group contract or other arrangement for payment of benefits such as described in Sections 1711, 1712 and 1715 shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in Section 1711, 1712 or 1715.

29. Further, Section 1719(b) of the Act defines "program, group contract or other arrangement" as including, but not being limited to, benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa.C.S.A. ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services corporations).

30. Nowhere in Sections 1711, 1712, 1715 or 1719 does the Act contemplate or specifically refer to a health plan such as FMC's which is self-insured.

31. The absence of such a reference in Subchapter B of the Act comports with federal public policy, as reflected in the ERISA statute, in favor of the establishment and maintenance of employee welfare benefit plans such as FMC's Health Plan.

WHEREFORE, FMC respectfully requests that this Court enter judgment in favor of FMC as follows:

(a) declaring that § 1720 relating to subrogation does not cover self-insured plans such as FMC's Health Plan;

(b) declaring that FMC is entitled to exercise its subrogation rights in this matter;

(c) directing Johnson on behalf of Ms. Holiday to cooperate with and otherwise facilitate FMC's exercise of its subrogation rights; and

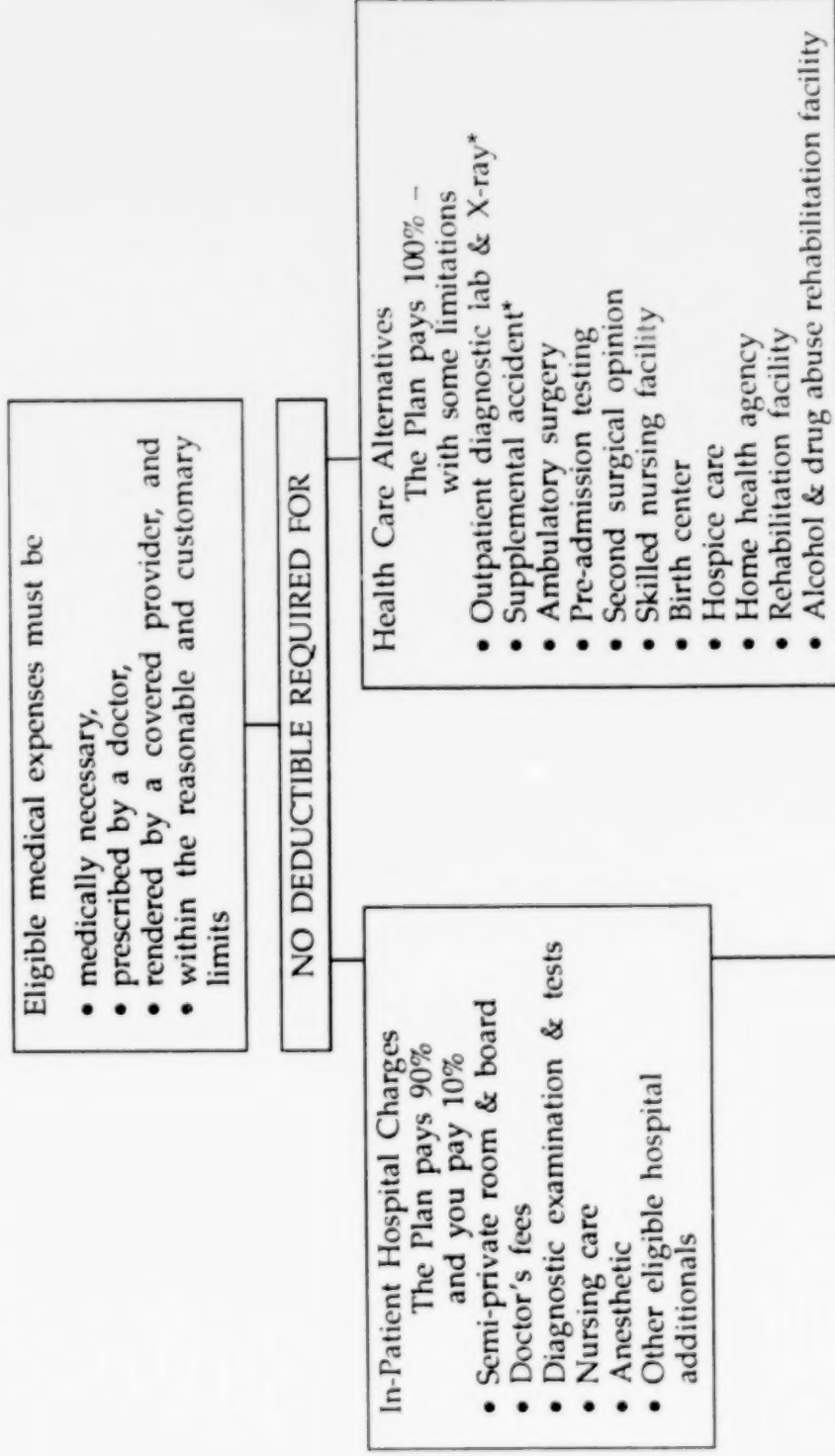
(d) granting such further relief as this Court deems just and proper, including FMC's costs and attorneys' fees.

Dated: May 16, 1988

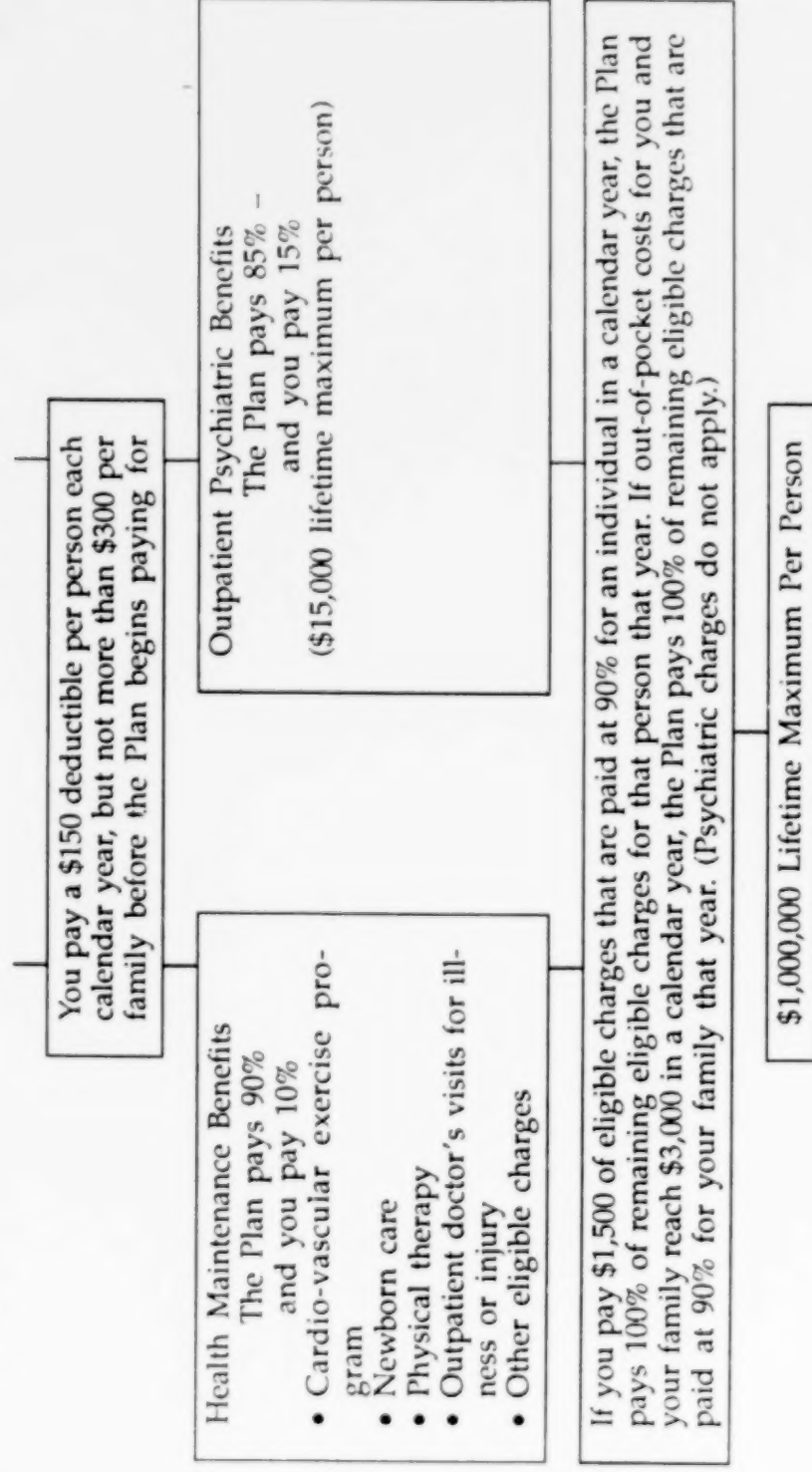
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## Summary of Your FMC Salaried Health Care Plan Benefits

Here's a summary of how the Health Plan helps pay eligible medical expenses for an individual during a calendar year.



\*\$1,000 maximum. Excess at 90%, after deductible.



The information in this section applies to salaried and non-union hourly employees at designated locations.

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## YOUR HEALTH CARE BENEFITS – A SUMMARY

To make good health care affordable.

The increasing cost of good medical care and treatment is a probable shared by all of us. Medical care costs in recent years have risen at a considerably faster pace than the prices for most other major family expenses. As a result, family finances could be seriously depleted by the medical expenses resulting from a severe accident or illness. Even the cost of some routine health care can be a short-term monetary problem. FMC health care benefits are designed to help you and your eligible dependents meet the financial impact of continually increasing medical costs.

The summary of benefits chart at the beginning of this section shows how the FMC Health Care Plan furnishes protection against most medical expenses that you and your family are likely to incur. There are four major parts to your FMC Health Care Plan:

### In-Patient Hospital Benefits

In-patient hospital benefits cover medically necessary charges for such items as room and board, drugs, doctor's fees and tests while you or your eligible dependents are confined in a hospital. The Plan pays 90% of eligible charges related to a hospital confinement, including any surgeon's fees. You pay the remaining 10%. There is no deductible requirement. There are limitations on confinements for psychiatric care, alcohol and drug abuse rehabilitation, skilled nursing care and comprehensive rehabilitation.

### **Health Care Alternatives**

There are several options available to help you avoid a costly hospital confinement. There is no deductible requirement for Health Care Alternatives. Your Plan covers these specialized facilities at 100% – with some limitations:

- Alcohol and drug abuse rehabilitation facility
- Rehabilitation facility
- Hospice care
- Skilled nursing facility
- Home health care
- Birth centers

The Plan also covers these Health Care Alternatives at 100%:

- Pre-admission testing
- Ambulatory, out-patient or same day surgery
- Second surgical opinion

If you require out-patient diagnostic x-rays and/or laboratory tests, the Plan pays 100% up to the first \$1,000 of charges. After the calendar year deductible is satisfied, the Plan then pays 90% for any additional charges.

Any accident-related charges on an out-patient basis (with the exception of chiropractic charges), if incurred within 90 days of the accident, are paid at 100% up to the first \$1,000 of eligible charges per accident with no deductible.

### **Health Maintenance Benefits**

This section of the Plan covers a wide range of health services such as out-patient doctors' visits, prescription drugs and cardio-vascular exercise programs. A deductible is required before the Plan begins paying benefits. This means you pay the first \$150 of expenses each calendar year, or \$300 for family members eligible under this Plan. After the deductible is satisfied, the Plan will pay 90% of all the reasonable and customary charges for the rest of that calendar year. Out-patient psychiatric charges, covered under this provision, are payable at 85% of eligible charges, subject to a \$15,000 life time maximum.

### **Catastrophic Coverage – Maximum Benefits**

Your Plan provides a \$1 million lifetime maximum benefit for you and each covered dependent in your family. In addition, once you pay \$1,500 per individual (\$3,000 maximum per family) per calendar year for eligible medical expenses which are normally covered at 90%, the Plan will pay 100% of those charges for the remainder of the calendar year.

It is important to note that charges for psychiatric care do not apply to the out-of-pocket maximum. You will always share in the cost of psychiatric care.

The Plan pays benefits for most non-occupational injuries and diseases. For work-related injuries and illnesses, there is no coverage under this Plan. See your local Human Resources representative for information on work-related accident or illness.

The following pages provide more details about your Health Care Plan.

## ESSENTIAL PLAN INFORMATION

### Effective Date

All of the information in this section is effective as of August 1, 1987.

### Eligibility – You

You are eligible to participate in the Medical Care Plan on the first day of the month coinciding with or next following the completion of a full calendar month of employment. To be eligible, you must also be:

- a salaried or non-union hourly full-time employee.
- employed by an FMC location that offers this Plan.
- not covered by a collective bargaining agreement.

To enroll, you must fill out the enrollment form provided by your Human Resources Department. If you wait more than 31 days after you are first eligible, you must furnish satisfactory proof of your good health at your own expense.

Coverage will become effective upon approval by the Claim Administrator. (You will also have to submit proof of good health if you are reapplying for coverage after your coverage has terminated for any reason except a change in your employee status.)

If you are absent from work on the day on which your coverage would normally begin, you will become covered on the day you return to active work.

Any person covered under a Health Maintenance Organization (HMO) paid by FMC, is not eligible for benefits under this or any other FMC Health Care Plan.

### Eligibility – Your Dependents

Dependents who are eligible for coverage under this Plan include:

- your spouse (unless legally separated),
- your unmarried children (related by marriage, parentage or law) less than 19 years old, and
- your unmarried children age 19 or over but less than age 23 who are full-time students, and
- mentally retarded or physically handicapped children 19 years old or older who are unmarried, incapable of self support and chiefly dependent on you for maintenance and support – as long as they were covered as your dependents under this Plan before the age of 19. To continue either a mentally retarded or physically handicapped child's coverage, you must apply to the Claim Administrator no later than 31 days before the child's 19th birthday. If continued coverage is approved, you will be asked periodically to furnish proof of your child's continuing disability.
- children for whom the employee has not assumed legal responsibility, such as children of married participants who have a child born outside of their marriage, will not be covered.

Eligible children, who meet the criteria above, must reside in your household in a parent/child relationship and/or be dependent upon you for support and maintenance. You will be asked periodically to furnish proof of your child's eligibility. This proof may consist of academic grade transcripts, course enrollment schedules or copies of Federal income tax returns. Full-time students are defined as those students who are enrolled in academic programs fulfilling 12 or more semester hours of credit.



No person is eligible as a dependent if eligible as an employee for this or any other FMC Health Care Plan, including an HMO. If you and your spouse are both covered for health care plan benefits as FMC employees, you and your spouse must choose the health care plan (including HMO's) under which the children will be covered as eligible dependents. The children can be enrolled in one of the spouses' health care plans, but not both. In addition, eligible children can participate in only one of the spouses' health care plans, not both. In other words, eligible children cannot be "split-enrolled" among the spouses' plans.

To cover your dependents under this Plan, you must complete an enrollment form indicating their eligibility. Their coverage will begin on the first day you are eligible to participate. If you do not enroll eligible dependents within 31 days of the time they are first eligible, they must furnish satisfactory proof of good health at their own expense in order to obtain coverage. Coverage will become effective upon approval by the Claim Administrator.

A dependent who is confined to the hospital (except at birth) must wait until the confinement ends to become covered under this Plan.

### **COST**

FMC Corporation pays the full cost of this Plan.

## **DEFINITIONS**

### **Reasonable and Customary**

Reasonable and customary charges means the fee charged by the provider for a service rendered or a supply furnished but only to the extent that the fee is reasonable, taking into consideration the following:

- The usual fee which the provider most frequently charges the majority of patients for the service or supply,
- The prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and
- Unusual circumstances or complications requiring additional time, skill and experience in connection with the procedure.

The term area means a metropolitan area, a county or such other geographical area or areas as is necessary to obtain a representative cross-section of a provider rendering services or furnishing such supplies.

Charges for services, supplies, or treatments (including unnecessary repetition of tests) that are not reasonable and customary (as determined by the Claim Administrator) will not be paid; you will be responsible for payment. Therefore, when possible, you should determine how the fees and procedures of your doctor and hospital compare with the norm in your region of the country before you made a final decision about where to receive treatment. Your Human Resources Representative can help you make this determination.

### Medical Necessity

Eligible charges will be covered only if the Claim Administrator determines them to be medically necessary. The fact that a physician or another provider has furnished, ordered or approved a service does not, of itself, make that service medically necessary. To be medically necessary, a service must be:

1. Consistent with the symptom or diagnosis and treatment of your illness or injury; and
2. Appropriate with regard to standards of good medical practice; and
3. Performed in the least costly setting where services can be solely and appropriately provided; and
4. Not solely for your convenience or that of your physician or the facility at which you receive treatment.

Any charges that cannot be reviewed by the Claim Administrator for medical necessity will not be covered by the Plan.

### Doctor and Other Providers of Service

A doctor is a person who is licensed to practice medicine including a chiropractor (see page 34), dentist, osteopath, podiatrist, psychiatrist and psychologist.

This Plan also recognizes the following state licensed allied health professionals as providers who practice under the direction of a legally qualified physician: clinical licensed social worker, speech therapist, physical therapist, licensed practical nurse (LPN), registered nurse (RN) and certified nurse midwife (CNM).

### Eligible Charge

An eligible charge means the Plan pays benefits only for reasonable and customary charges that are the result of a non-occupational illness or injury. All charges must be for services or items recommended by a doctor and necessary for medical care.

### Prescription Drugs

A prescription drug means any medicinal substance which is required to bear the label "Caution: Federal law prohibits dispensing without prescription". This also includes compounded medications which contain at least one such medicinal substance. Contraceptive medications are excluded.

### Hospital

A hospital is a legally operated institution, approved by the Joint Commission on Accreditation of Hospitals, that provides care through organized diagnostic and surgical facilities. Supervision by a staff of doctors and a 24-hour-a-day service by registered nurses must be available. The term "hospital" does not include an institution, or part of one, used mainly for rest care, nursing care, convalescent care, care for the aged, care of the chronically ill, educational care or custodial or maintenance care that cannot reasonably be expected to substantially improve a medical condition. Charges from an institution which is not considered a hospital are not eligible for payment. (There is a special coverage for ambulatory surgical facilities, rehabilitation hospitals, alcohol and drug abuse facilities,

and skilled nursing facilities. See page 16 for specific Plan provisions and limitations.)

### **Ambulatory Surgical Center**

A surgical center is a facility equipped to handle surgical procedures that require hospital facilities but do not require a hospital stay.

In order to qualify, a surgical center must be established, equipped and operated for the performance of surgical procedures by doctors. It must have an organized medical staff; equipment and supplies not usually available to a doctor outside a hospital, including operating rooms, a recovery room, diagnostic facilities, and emergency equipment, full-time registered professional nurses, and a written agreement with a nearby hospital to accept patients who develop complications.

### **Local Ambulance Service**

Local ambulance service is medically necessary ambulance transport to the nearest hospital providing emergency medical care. This also includes non-emergency transportation such as to a rehabilitation hospital, skilled nursing facility or transfer to home during a terminal phase of illness as long as the transportation is medically necessary.

### **Pain Center**

A pain center is a licensed facility with trained and licensed personnel-capable of evaluating, managing and

treating a variety of chronic pain syndromes. (See page 33 for specific Plan provisions and limitations.)

### **Home Health Agency**

A home health agency is a public or private agency or organization, or part of one, that mainly provides skilled nursing and other therapeutic services. It must be legally qualified in the state or locality in which it operates. It must keep clinical records on all patients. The services must be supervised by a doctor or registered nurse (R.N.); and they must be based on policies set by associated professionals, which include at least one doctor and one registered nurse. This does not include a home health agency used mainly for the care the treatment of mental, nervous or emotional conditions.

### **Birth Center**

An out-of-hospital, free standing birth center is an ambulatory care facility providing safe, low cost, comprehensive maternity care to healthy families who have participated in sound prenatal screening and care and are anticipating a normal birth. The center is an adaptation of the home rather than a modification of the hospital. Birth centers must meet criteria of the Claim Administrator.

### **Optional Pre-Treatment Benefit Review**

To help you know in advance what medical expenses are covered by the Plan, the Claim Administrator, who handles the payment of benefits, offers a pre-treatment benefit review service. If you or a member of your family is



about to undergo a major, non-emergency medical procedure or a series of treatments, you can use this optional service to find out what benefits the Plan will pay. To do so, obtain a detailed written description of the anticipated services, charges and diagnoses from your physician before the treatment begins. This information should then be forwarded to the Claim Administrator. You should allow at least 30 days for a response.

You'll be advised how the Plan will help you pay for the treatment.

### IN-PATIENT HOSPITAL BENEFITS

#### 90% Coverage – No Deductible

Your Plan pays 90% of total eligible charges for expenses as a result of an illness or injury related to hospitalization including:

- Room and board charges for ward, semi-private or the intensive care unit. Private room and board charges are also paid when evidence of medical necessity is submitted by your doctor and concurred with by the Claim Administrator. (If you stay in a private room by your own choice, the Plan pays a rate equal to the hospital's most common charge for a semi-private room. You must pay the cost difference between a semi-private and private room.)
- Reasonable and customary doctor's fees
- Diagnostic examinations and tests when they are related to the illness or injury causing hospitalization
- Prescription drugs and medications
- Nursing care (includes hospital staff nurses, but does not include private duty nursing care)
- Use of the operating, recovery and delivery rooms

- Anesthetics and their administration
- Physical therapy
- Oxygen and its administration
- Dressings, casts, splints
- Radiation therapy
- Administration of blood and blood plasma, also blood, if not replaced by a blood plan
- Medically necessary local ambulance transport
- In-patient psychiatric care is limited to 120 days per person in a 365 consecutive day period beginning with your first day of confinement. Regular progress reports from the doctor to the Claim Administrator will be required to assure that the confinement is medically necessary.
- In-patient care for alcohol or drug dependency is covered at 100% up to the first 30 days of confinement. A second admission is covered at 50% for up to 30 days of confinement. A confinement may be less than 30 days, however, charges incurred in excess of 30 days for each confinement are not covered. There is a lifetime maximum of two covered confinements per person.

Benefits are not paid for personal convenience items, such as television, telephone, admission kits.

#### Non-Emergency Week-end Admission Limitation

If you or an eligible dependent is admitted to the hospital on a Friday or Saturday, no benefits are payable for any hospital-related expenses incurred during that first week-end (Friday, Saturday, Sunday.) However, full Plan benefits are payable to you if you are admitted because of an emergency or if surgery is being performed that week-end. An emergency means a sudden, unexpected medical

condition that, without immediate medical attention, could result in death or cause impairment to bodily functions.

### **Doctor's Charges Related to Hospital Confinement**

The Plan will pay 90% of the reasonable and customary doctor's charges (no deductible) for treatment while you are confined in the hospital.

### **Maternity Benefits**

Maternity benefits are payable to employees and eligible dependents if pregnancy related expenses occur while coverage under this Plan is in effect.

**Hospital Delivery** – If you are confined to a hospital, expenses related to your maternity care are paid at 90%. This includes:

- Hospital room and board
- Hospital additional
- Reasonable and customary doctor's fees
- Prenatal and postnatal care (including prescription drugs)

**Birth Center** – If you receive maternity care in a birth center, the Plan pays 100% of the covered charges. (See Health Care Alternatives, page 19.)

**If you terminate employment with FMC and you or an eligible dependent is pregnant, health coverage, including maternity coverage, ceases on the day you terminate employment. (Of course, you can insure continued coverage by electing health care continuation coverage as explained on page 55.)**

### **Surgery Charges**

**In-Patient Surgery** – If you receive surgery while hospitalized, the Plan pays 90% of the reasonable and customary doctor's fees for surgery. The eligible covered charge for an assistant surgeon is 20% of the primary surgeon's reasonable and customary fee.

**Ambulatory Surgery (out-patient or same day)** – If you receive surgery on an out-patient or ambulatory basis, the Plan pays 100% of the reasonable and customary doctor's fees for surgery. (See "Health Care Alternatives", page 19.)

**A second surgical opinion is required for 16 surgical procedures. (See "Health Care Alternatives", page 21.)**

Benefits are payable for charges by a doctor of dental surgery (D.D.S. or D.M.D.) only for these cutting procedures for treatment of disease or injury of the jaw:

- Removal of impacted wisdom teeth
- Cutting to realign the jaw bone (osteotomies)
- Repair of dislocated or fractured jaw
- Removal of tumors and cysts
- Restoration for accidental injury to sound natural teeth only if the injury occurred while you were covered under this Plan

Benefits for other dental procedures may be covered under your Dental Care Assistance Plan. Please refer to your Dental Plan description for additional information.

### Oral Surgery Hospital Confinement Limitation

The Plan will not pay for any in-patient or out-patient hospital benefits, including anesthesiologist, for any oral surgery unless a medical doctor (M.D. or D.O. – not D.D.S. or D.M.D.) provides evidence, IN ADVANCE, to the Claim Administrator, that hospitalization is medically necessary. Medically necessary conditions include, for example, severe hypertension, severe diabetes or a disabling cardiac condition. You must be admitted by an M.D. or D.O. Apprehension, regardless of age, does not entitle you to benefits for dental admissions. (See Medical Necessity definition, page 12.)

### HEALTH CARE ALTERNATIVES

#### 100% Coverage – Some Limitations – No Deductible

A number of approved and licensed health care facilities are available which offer quality, specialized care as an alternative to costly hospital confinement. **Any health care facilities covered under this provision of the plan must be approved by the Claim Administrator as meeting established standards, including any legal licensing requirements of the state or locality in which it operates.**

Your Plan covers the following specialized health care facilities at 100% with some limitations:

#### Ambulatory Surgery (Out-Patient or Same Day)

The Plan pays 100% of the reasonable and customary doctor's fees for ambulatory surgery versus 90% of the surgeon's fees if you are hospitalized.

Ambulatory surgical facilities, sometimes called out-patient or same-day surgery facilities, are equipped for many surgical operations such as:

- Cataract surgery
- Inguinal hernia repair
- Tonsillectomy and adenoidectomy
- Uncomplicated orthopedic procedures
- Dilation and curettage
- Cystoscopy

The Plan pays 100% of the eligible charges for expenses related to the use of the ambulatory surgical facility. Eligible charges include the same items covered as if you were hospitalized for the surgical procedure (See In-patient Hospital Benefits, page 16.)

By using an ambulatory surgical facility instead of staying overnight in a hospital, you begin your recovery that same night in the comfort of your own home, rather than in the unfamiliar surroundings of a hospital. Children especially enjoy this advantage, being at home among family and friends at a time when they need extra support and comfort. Furthermore, your family avoids the inconvenience of visiting the patient in the hospital. Since there is a financial incentive for any surgery to be performed on an ambulatory or out-patient basis, you should discuss the possibility of using one of these facilities with your doctor, whenever the need for surgery arises.

There are several types of ambulatory surgical facilities: free-standing or a part of an acute care hospital. Your Human Resources Representative can provide you with



confirmation that a particular hospital or free-standing ambulatory surgical facility is approved by the Claim Administrator.

### Example of Ambulatory Surgery vs. In-patient Surgery

Your dependent needs a tumor removed from her wrist. Here's how the Plan would provide coverage if she has ambulatory (same-day) surgery versus being hospitalized.

Total Eligible Medical Services	TOTAL EXPENSES	
	Ambulatory Surgery	In-Patient Surgery
Hospital room & board	None	\$ 200
Hospital additional	None	300
In-patient doctor's visits	None	50
Surgeon's fee	\$750	750
Surgical Center Fee	<u>200</u>	<u>None</u>
Total Expenses	\$950	\$1,300
	Plan Pays	Plan Pays
	100%: \$950	90%: \$1,170
	You Pay	You Pay
	Nothing: <u>\$ 0</u>	10%: <u>\$ 130</u>

### Voluntary Second Opinion

Second opinions are often wise to obtain when there is a difference in medical opinion, you are not responding to treatment, or when a diagnosis, treatment, or surgical procedure could radically change the course of your or an

eligible dependent's life. A second opinion may prevent unnecessary medical or surgical intervention, offer an alternative therapy and, of course, provide you with peace of mind. The Plan will pay the full reasonable and customary fee for a second medical or a voluntary surgical opinion. You may choose any doctor for the second opinion as long as the doctor is an appropriate board certified specialist.

### Mandatory Second Surgical Opinion

Studies have shown there is a great deal of unnecessary elective or non-emergency surgery being performed. The second surgical opinion program is meant to lessen your chances of having unnecessary surgery and, of course, to reassure you that surgery is necessary.

The Health Care Plan will pay 100% of the reasonable and customary doctor's fee as well as for charges for tests necessary for you to receive a second opinion before undergoing **any** surgery.

If a doctor recommends one of the elective surgeries listed below, you **must** consult with another doctor (a board-certified specialist) prior to surgery to receive full medical benefits for all charges related to the surgery.

- Bunionectomy (removal of bunion)
- Cataract removal
- Cesarean section
- Cholecystectomy (removal of gall bladder)
- Coronary bypass
- Dilation and Curettage (D&C)

- Hemorrhoidectomy (not required for ligation technique)
- Herniorrhaphy (hernia repair)
- Hysterectomy (removal of uterus)
- Knee surgery (including excision of knee cartilage)
- Laminectomy (removal of part of vertebrae)
- Ligation and stripping of varicose veins
- Mastectomy and other breast surgery (not required for a breast biopsy)
- Prostatectomy (removal of part or all of the prostate gland)
- Submucous resection (repair of deviated septum)
- Tonsillectomy and/or Adenoidectomy

You may choose any doctor for the second opinion provided he/she is a board-certified specialist in treating your particular medical condition and is not financially or professionally associated with the first doctor who recommended the surgery. If the first and second opinions differ, the Plan also provides for full payment for expenses incurred if you seek a third surgical opinion from a board-certified specialist.

If you have the surgery for any one of the 16 required procedures and a second or third surgical opinion has been secured, regardless of the recommendation, the Plan pays full Plan benefits for charges related to the surgery (surgeon's fee, anesthesiologist's fee, pre-admission testing, hospital charges, etc.).

If you have the surgery without receiving a second surgical opinion, the Plan only pays 50% of all charges related

to the surgery (surgeon's fee, anesthesiologist's fee, pre-admission testing, hospital charges, etc.).

A second surgical opinion claim form must be completed prior to surgery by both doctors rendering surgical opinions. These forms are available in the Human Resources Department. The Plan does not cover doctor's charges for completion of the claim forms.

To avoid unnecessary duplicate testing, you should provide the second opinion doctor with any test results from the first doctor who recommended surgery.

The second surgical opinion requirement for these 16 procedures applies whether you have surgery while hospitalized or if you have surgery on an ambulatory (same day) basis.

If Medicare is your primary coverage, a mandatory second surgical opinion is not required to receive full FMC Health Plan benefits.

### **Example of Mandatory Second Surgical Opinion**

Your spouse's doctor recommends that she have a hysterectomy. Here's how the Plan would provide coverage if your spouse received a second opinion prior to the surgery and if she had the surgery without getting a second opinion.

<b>Total Eligible Medical Services</b>	<b>Total Expenses</b>
Hospital room and board	\$1,400
Hospital additional	4,200
Surgeon's fee	1,500
Anesthesiologist's fee	500
In hospital doctor visits	400
	<u>\$8,000</u>
If second opinion secured:	
Plan pays 90%	\$7,200
You pay 10%	\$ 800
If no second opinion secured:	
Plan pays 50%	\$4,000
You pay 50%	<u>\$4,000</u>

### Alcohol & Drug Abuse Rehabilitation Facility

If you or any eligible dependent require treatment for alcoholism or drug abuse, you can obtain effective treatment in a facility specializing in such care as an alternative to a full-service hospital. Treatment must be prescribed by a doctor. The alcohol or drug abuse facility must be licensed and approved by the Joint Commission on Accreditation of Hospitals. An effective treatment program includes individual therapy by a physician or group therapy, and an intention to enter into and remain in a comprehensive follow up program. The follow up program must include therapy at least once a month by a physician or group therapy under a physician's direction, plus attendance at least twice a month at meetings or

organizations devoted to the therapeutic treatment of alcoholism, chemical dependency, or drug addiction. Half-way houses or extended treatment centers are not covered.

Charges from an alcohol or drug abuse rehabilitation facility are covered at 100% up to the first 30 days of confinement. A second admission is covered at 50% for up to 30 days of confinement. A confinement may be less than 30 days, however, charges incurred in excess of 30 days for each confinement are not covered. There is a lifetime maximum of two covered confinements per person.

### Example of Alcohol & Drug Abuse Rehabilitation Facility

Let's suppose you needed to be hospitalized for 30 days for treatment of alcoholism. Here's how the Plan would cover your expenses in a full-service hospital and in a specialized alcohol treatment facility:

<b>Total Eligible Medical Services</b>	<b>Total Expenses</b>
Room & Board	\$6,000
Doctor's visits	500
Additional	<u>2,000</u>
	<u>\$8,500</u>



**Full-service Hospital:**

Plan pays 90%	\$7,650
You pay 10%	\$ 850

**Alcohol Treatment Facility:**

Plan pays 100%	\$8,500
You pay nothing	<u>\$ 0</u>

**Rehabilitation Facility**

Rehabilitation facilities offer comprehensive, physical rehabilitation for victims of stroke, birth defects, accidents and other disabling conditions. Charges from an approved rehabilitation facility are covered at 100% up to the first 30 days of confinement. A second admission is covered at 50% for up to 30 days of confinement. A confinement may be less than 30 days. However, charges incurred in excess of 30 days for each confinement are not covered. There is a lifetime maximum of two covered confinements per person.

- Comprehensive treatment for chronic pain is covered under this provision. The coverage has a lifetime limit of 10 days and must meet the Claim Administrator's criteria and approval.

**Hospice Care**

A hospice is a facility that offers a coordinated program of home care and in-patient care for a terminally ill patient and the patient's family. The program provides supportive care to meet the special needs from physical,

psychological, spiritual, social and economic stresses which are often experienced during the final stages of terminal illness and during dying and bereavement.

The Plan covers hospice charges for terminally ill covered employees and for members of the patient's family who are covered as dependents under this Plan. A terminally ill patient is someone who has a life expectancy of approximately six months or less, as certified in writing by the doctor who is in charge of the patient's care and treatment. If you are in a hospice program, the Plan will pay 100% of covered charges for:

- In-patient health care
- Services of a physician
- Health care services at home – including part-time nursing care, use of medical equipment, rental of wheelchairs and hospital-type beds, and homemaker services
- Emotional support services, physical and chemical therapies
- Bereavement counseling sessions for family members

The maximum benefit payable for all hospice charges in connection with a terminally ill patient is \$5,000. When this limit is reached, payments for medical services will be made if they are covered under other parts of the Health Care Plan. These hospice benefits are in place of all other benefits provided under any other part of the Plan for the same services. During the 12 months following the death of the terminally ill patient, the Plan will pay up to \$25 for each bereavement counseling session for covered family members, up to a limit of 12 sessions.

### Skilled Nursing Facility

A skilled nursing facility may be a skilled nursing home, or a distinct part of an institution, such as a ward or wing of a hospital, or a section of a facility another part of which is a geriatric center. An approved facility must be primarily engaged in providing skilled nursing care or rehabilitation services. At least one registered nurse must be employed full-time and adequate nursing service (which may include practical nurses) must be provided at all times. Every patient must be under the supervision of a doctor and a doctor must always be available for emergency care. The facility must be certified by the state. It also must have a written agreement with a hospital that is participating in the Federal Government's Medicare program for the transfer of patients. Not all nursing homes will qualify; those which offer only custodial care are excluded.

After a stay in the hospital, you may still need special medical care but to a lesser degree than a hospital provides. You can receive that care in an approved skilled nursing facility. Your physician must certify medical necessity for transfer from a hospital to an approved skilled nursing facility within 3 days of your hospital discharge date. The Plan pays 100% of the reasonable and customary charges for room and board and medical services for up to 30 days per person per calendar year. **The emphasis is on rehabilitation – helping you fully recuperate and return to a productive life. Charges from a skilled nursing facility will not be covered if the services received are personal or custodial care such as help with bathing, dressing or eating. If you are readmitted within 14 days of discharge from a skilled nursing facility**

**and you have not exhausted the 30 day limit, it is considered the same confinement.**

### Home Health Care

Home health care means you can receive necessary medical care in your own home and avoid a long, costly hospital stay. The Plan provides 100% of reasonable and customary charges for up to 60 home health care visits per person per calendar year. **A visit is limited to two hours in any 24 hour period. Your attending physician must prescribe home health care and you must begin the program within 14 days after discharge from the hospital or from a skilled nursing facility. Home health care must be directly related to the condition for which hospitalization was required. Care is provided by licensed and Plan approved home health care agencies and includes such services as therapy, nursing care, medical social services, diagnostic services and other medical services to help you while you are confined to your home.** Benefits are not payable for custodial care such as the provision of meals, housekeeping or other non-medical assistance. Physician visits are covered under Health Maintenance benefits.

### Birth Center

A birth center is a facility where healthy women can participate in prenatal screening and have their baby in a home-like atmosphere. Approved facilities are staffed by certified midwives, physicians and other trained personnel. Facilities consist of birthing rooms, living room, kitchen facilities and a family waiting room. Birthing

centers have the necessary medical equipment, backup physicians and written agreement to transfer to a hospital if necessary. Discharge is usually within 24 hours when mother and newborn are stable. The birth center offers a satisfying and enriching childbirth experience. The Plan covers 100% of the reasonable and customary charges from a Plan approved and licensed birth center.

### **Homebirths**

An increasing number of expectant mothers are deciding to give birth at home, necessitating the provision of safe, homebirth services for those individuals who choose this alternative. For this reason, certain criteria must be fulfilled. The Plan covers 100% of the reasonable and customary charges from a Plan approved homebirth program.

### **Other Health Care Alternatives**

If the need arises, you should discuss with your doctor the possibility of using one of these special health care alternatives to costly in-patient hospital care. You may save yourself time and money and receive more specialized care.

### **Pre-Admission Testing**

Your Plan pays 100% of covered charges for pre-admission testing (i.e., x-rays and laboratory tests, etc.) incurred on an out-patient basis within 14 days prior to a hospital confinement. There is no deductible required for pre-admission testing. The charges must be related to the

sickness or injury that ultimately causes confinement. However, if you receive these tests while hospitalized, the Plan pays 90% of the charges and you pay the additional 10% of charges. Pre-admission testing that is repeated in the hospital will not be paid unless medically necessary as determined by the Claim Administrator.

### **Out-Patient Diagnostic X-ray & Laboratory Charges**

Your Plan pays 100% of the first \$1,000 of eligible charges per calendar year for out-patient diagnostic x-ray and laboratory tests. Additional charges are covered at 90%, after the deductible is satisfied. Allergy tests are covered under this provision. Any diagnostic x-ray and laboratory tests performed while confined to the hospital are covered at 90%.

### **Charges Resulting from an Accidental Injury**

Your Plan pays 100% of the first \$1,000 of eligible out-patient charges per accident that are incurred within 90 days of an accident. Charges over \$1,000 are covered at 90%, after the calendar year deductible is satisfied. Charges related to an accidental injury incurred after 90 days are also covered at 90%, after the calendar year deductible is satisfied. The accident must have occurred while you were covered by this Plan. Services provided by a chiropractor in an accident situation are specifically excluded under this provision of the Plan, but are included under the special chiropractic provisions of this Plan. (Please see page 34).

Some of the charges resulting from an accident may also be covered under other provisions of your Health Plan.



For example, if you are admitted to the hospital for treatment as a result of an accident, the Plan provides 90% of covered charges, no deductible (instead of 100% coverage). As such, there is a financial incentive to have accident-related treatment performed on an out-patient basis instead of an in-patient basis.

### **Out-Patient Emergency Illness**

Out-patient emergency medical care benefits are **not** subject to deductible and are paid at 90%. This includes hospitals, physician services and emergency ambulance transport. Emergency illness is a sudden unexpected medical condition requiring immediate medical attention – such as loss of breath, severe chest pains, sudden blindness or other acute conditions with symptoms severe enough that the absence of medical attention could reasonably result in death or cause impairment to bodily functions of the patient.

A chronic condition in which symptoms have existed over a period of time would not qualify for medical emergency consideration. Medical care must be provided within 48 hours of onset of the illness.

Note: Charges for the use of the hospital emergency room for a non-life threatening medical condition are subject to the deductible and are payable at 50%. Exception: You are out-of-town and immediate access to a non-hospital based physician is not timely.

## **HEALTH MAINTENANCE BENEFITS**

### **90% Coverage – Deductible Required**

Your Health Maintenance Benefits are designed to help pay expenses for certain services and supplies not covered under other parts of the Plan. All Health Maintenance services must be necessary to treat illness or injury and the provider of services must meet the Plan's definition of a doctor defined on page 13.

### **The Deductible**

You are responsible for the first \$150 in a calendar year of any charges covered under this part of the Plan. This \$150 amount is called the deductible. It applies to each covered person once each calendar year. Once the deductible for the calendar year has been met, the Plan pays 90% (85% for out-patient psychiatric) of all the remaining covered expenses for the rest of that calendar year.

Once two or more eligible members of your family have applied \$300 towards the Plan deductible in the same calendar year, no additional deductible will be required for your family during that calendar year. No person can apply more than \$150 of covered expenses toward the family limit of \$300.

### Example of Individual Deductible

Let's assume one individual incurs the following expenses.

Eligible Expenses	\$ 280
minus	
Individual Deductible	- 150
Expenses After Deductible	\$ 130
times	
Benefit Payment Percentage	x90%
Benefit Pays	<u>\$ 117</u>

### Example of Family Deductible

The chart below shows how a family's expenses are applied to the family deductible.

Family Member	Expenses Eligible for Benefit	Expenses Applied to \$300 Family Deductible
1	\$ 75	\$ 75
2	750	150
3	100	75
4	100	-
5	+ 75	+ -
	<u>\$1,100</u>	<u>\$300</u>

The plan would then pay these benefits:

Eligible Expenses	\$1,100
minus	
Family Deductible	- 300
Expenses After Deductible	\$ 800
times	
Benefit Payment Percentage	x 90%
Benefit Pays	<u>\$ 720</u>
SUMMARY	
Total Charges:	\$1,100
Benefit Pays:	- 720
You Pay:	<u>\$ 380</u>

Expenses that are considered Health Maintenance Benefits payable at 90% of the reasonable and customary amount, after the deductible is satisfied, include:

### Cardio-Vascular Exercise Regimen

• A cardio-vascular exercise regimen is a course of medically supervised exercise therapy to improve efficiency of the heart, lungs, and circulatory system. The treatment facility must be an approved center, hospital, or rehabilitation hospital. The provider of care must be a board-certified cardiologist. The program must use telemetry, monitoring and be equipped with appropriate emergency equipment. A person is eligible for this benefit only if the regimen is prescribed by a doctor under these conditions:

- Stable angina pectoris (chest pain)
- High risk coronary artery disease -
- Following a heart attack
- Following heart bypass surgery
- Individuals with clinical symptoms of heart disease

- Coverage includes:

- Initial physical examination, history and physical performed by a cardiologist
- X-ray and laboratory tests
- Exercise visits

There is a \$1,000 lifetime maximum per person for all charges related to a cardio-vascular exercise regimen, including x-ray and laboratory tests.

#### Other Covered Charges

- Newborn childcare – Newborns require routine medical care, especially during the early years following birth. Our Plan covers up to five office visits for routine check-ups – including doctor's fee, lab tests and immunizations – during the baby's first 12 months and Two routine check-ups during the baby's second year.
- Immunizations – to prevent illness.
- Dietary instruction for diabetes – when prescribed by a doctor.
- Prescription Drugs – obtainable only by a doctor's prescription and filled by a pharmacist for treatment of an illness or injury. See definition of prescription drug on page 13.
- Biofeedback – up to a maximum of 25 treatments per calendar year. If the treatment is in connection with a mental or nervous condition, the Plan's psychiatric limitations and maximum apply. (See page 35.)
- Acupuncture – 8 initial treatments; no treatment for 30 days; then 6 additional treatments over a 9-month period.
- Out-patient doctor visits – when required as a result of illness or injury. Routine doctor's visits are not covered, except for newborn childcare benefits as described on page 32.

- Physical therapy – when prescribed by a doctor for reasonable & customary treatment of disease, bodily injury, or defects. (See Optional Pre-Treatment Benefit Review, page 15.)

- Up to a maximum of 35 treatments per calendar year
- Restoration of treatment if surgery occurs, or for an unrelated condition

- Speech therapy – when prescribed by a doctor for treatment of a condition that arises from a non-occupational injury or illness. The patient must have the capacity to verbally communicate at the time therapy is begun. Speech therapy for education or training is not covered.

- Pain therapy – when prescribed by a doctor for the evaluation and treatment of **chronic** pain due to a non-occupational injury or illness.

The program should help the patient develop pain management techniques that will help lead as normal a life as possible. After initial evaluation, a written plan of therapy must be submitted to the Claim Administrator. Examples of chronic pain therapy centers include: Spinal cord injury pain; Low back pain; and Cancer pain centers. The pain clinic or center must fulfill the criteria of the Claim Administrator. Coverage is limited to two lifetime one-to-four week outpatient pain therapy programs.

(Some pain therapy treatments are covered under other provisions of the Plan, i.e., acupuncture, and biofeedback).

- Chiropractic care – benefits will be provided for chiropractic care and consist of spinal adjustments of subluxations which may cause acute and chronic conditions. Common measures of case management and procedures to monitor the patient's progress must be outlined and



submitted to the Claim Administrator. Chiropractors must practice within the limits of licensure and includes:

- Case History
- Physical findings (subjective and objective)
- Spinal Examination
  - Visual
  - Digital
- X-rays
- Other pertinent chiropractic procedures

It does not include:

- Maintenance care
- Preventative examinations
- Treatment for mental/nervous disorders
- There is a \$500 calendar year maximum. Claims may be reviewed by a Chiropractic Claim Review Committee at the discretion of the Claims Administrator.
- Local ambulance service
- Oxygen and blood
- Private duty nursing (RN or LPN)
- Chemotherapy and radiation therapy
- Prescribed, durable medical equipment and appliances (such as hospital beds, respirators and wheel-chairs) primarily used in treatment and generally not useful in the absence of illness or injury. Equipment or appliances for convenience, accommodation or household use are not considered durable medical equipment. A written prescription from a doctor is required and the Claim Administrator determines whether or not the appliance or equipment is covered under the Plan. If less expensive, the equipment should be purchased rather than rented. If

rented, the total rental fees cannot exceed the purchase price. If the price of the purchased item is \$500 or greater, the purchase must be approved in advance by the Claim Administrator.

#### **Out-Patient Psychiatric Care – Covered at 85%**

Out-patient psychiatric charges are payable at 85% (after the deductible requirement) and are subject to a \$15,000 lifetime maximum benefit per person. Psychiatric day care, an alternative to hospitalization, is also covered under this section.

The eligible expenses for out-patient psychiatric care is limited to the fees of:

- a psychiatrist (M.D.)
- a psychologist who is a member of the American Psychiatric Association and is licensed by the state in which he or she practices.

Services must be provided as an individualized treatment plan on the basis of evaluation of the patient's restorative potential and the treatment must be reasonably expected to improve the patient's condition. Individual or group therapy which is rendered by either a psychiatrist or psychologist is limited to one session per week but not to exceed the \$15,000 lifetime maximum.

The disorder being treated must be included in the mental or nervous conditions defined by the American Psychiatric Association. Charges for out-patient treatment for alcohol and drug abuse are covered under this provision. This benefit does not cover educational testing, learning disabilities, mental retardation or marriage and family counseling. Charges from a Licensed Marriage, Family

and Child Counselor are not covered. If you have questions about specific coverage you should request a pre-treatment review from the Claim Administrator.

There is no reinstatement of the \$15,000 lifetime maximum. All claims are subject to a progress review at the discretion of the Claims Administrator.

### MEDICAL CASE MANAGEMENT

Medical Case Management is a program to assure quality health care while controlling high health care costs connected with a severe personal injury or sickness. "Severe personal injury or sickness" means any of the following which result in the person becoming totally disabled:

- major head trauma
- spinal cord injury
- amputations
- multiple fractures
- severe burns
- neonatal high risk infants
- severe stroke
- multiple sclerosis
- amyotrophic lateral sclerosis
- end stage cancer
- acquired immune deficiency syndrome (AIDS)

The objectives of this program are to find and cover care conscious and cost conscious medical alternatives. Medical alternatives means services and supplies which:

- may not be covered under other parts of the plan;
- can be used in place of other services and supplies that are covered elsewhere; and
- are more appropriate in the long term care of the patient.

The flexibility of this program allows all options of care to be explored and considered for coverage based on the uniqueness of each case. The program will begin when a person covered for medical benefits suffers a severe personal injury or sickness based on an objective review.

Benefits under this program will be paid in accord with the following provisions:

- Benefits will be paid for reasonable and customary charges for services and supplies furnished to the patient.
- Benefits will be paid to the extent that they are in excess of the total benefits payable for such charges under all other parts of the plan.
- The injury or sickness must happen and all charges must be incurred while the patient is covered under the plan.
- The amount of the benefit payment for these charges will be determined by the Plan Administrator.
- The maximum benefit is subject to the overall lifetime maximum under the Plan.

### CATASTROPHIC PROVISION

#### \$1 Million Dollar Maximum

If you or an eligible member of your family face a serious illness or injury, your Health Care Plan helps prevent you from suffering severe financial hardship due to catastrophic medical expenses.

The plan provides a \$1 million dollar lifetime maximum benefit per person.

Additionally, if you or an eligible member of your family pay more than \$1,500 in eligible medical expenses under this Plan (including the deductible) during a calendar year, the Plan pays 100% of all additional eligible charges that are normally paid at 90% for that person during the rest of that calendar year. This is called the "out-of-pocket expense limit". There is a similar limit for your family's out-of-pocket expenses. If out-of-pocket costs for you and your family under this Plan reach \$3,000 in a calendar year, the Plan pays 100% of the remaining eligible expenses that are normally paid at 90% for the rest of that calendar year. In other words, regardless of how high your eligible medical expenses are in a calendar year, you will not pay more than \$1,500 for your eligible expenses or \$3,000 for your entire family's eligible expenses that are normally paid at 90%.

**There is one exception to this catastrophe coverage – in-patient and out-patient psychiatric charges do not apply to the out-of-pocket maximum; however, they do count toward reaching the \$1 million maximum.**

#### Example of Catastrophic Coverage

If you became seriously ill and were hospitalized, the Plan would provide coverage in the following way:

Total Eligible Medical Services	Total Expenses
Ambulance	\$ 50
Hospital room and board	1,800
Hospital additional	12,000
Surgeon's fee	4,000
Anesthesiologist's fee	1,000
In-hospital doctor visits	350
	<u>\$19,200</u>
• Plan pays 90% of first \$15,000	\$13,500
• You pay 10% of first \$15,000	\$ 1,500
• Plan pays 100% of remaining expenses	\$ 4,200
<b>SUMMARY</b>	
Total Charges:	\$19,200
Plan pays:	\$17,700
You pay:	<u>\$ 1,500</u>

Your individual out-of-pocket maximum of \$1,500 was met. For the rest of the calendar year, the Plan will cover 100% for most additional eligible expenses for you.



## EXPENSES NOT COVERED

The Plan's purpose is to help pay expenses which are for prescribed and necessary treatment of illnesses or injuries within the reasonable and customary limits. Some expenses, even if prescribed, are not covered. The Plan does not cover:

- Charges in excess of reasonable and customary charges. (See page 12 for a definition of reasonable and customary.)
- Charges which are not eligible charges (See page 13 for a definition of eligible charge).
- Charges for medical treatment (including hospitalization) not necessary for medical care, is not an acceptable medical practice, or for medical treatment which is experimental. The determination of necessary or experimental will be made by the Claim Administrator and your physician's opinion does not make the medical care necessary, or in the case of experimental treatment, your physician's opinion does not define the scope of treatment.
- Charges which exceed any of the Plan's maximums.
- Expenses incurred as a result of a work-related injury or illness, regardless of coverage under workers' compensation or other employer liability laws. This includes self-employment.
- Charges which you are not legally required to pay, or are provided by law, or which would not have been made if you were not covered by this Plan.
- Treatments prohibited by law or non-FDA approved drugs.
- A service or supply not ordered by a doctor.
- Expenses connected with cosmetic surgery unless due to an accident while covered, or for correction of congenital anomaly for children born while the mother is covered under the Plan.

- Charges for eye refractions (including surgery), vision training, eye glasses, corrective contact lenses or any procedures that correct a refractive error, or hearing aids or for examinations to determine the need for or adjustment of eyeglasses or hearing aids. This exclusion also includes expenses connected with radial keratotomy.
- Charges for treatment on or to the teeth, gums or surrounding tissues other than those specific procedures described under "Surgery" on page 18.
- Charges for any treatment of appliances for TMJ (temporomandibular joint syndrome) including surgery and/or hospitalization.
- Charges for routine or annual medical checkups except for diagnostic X-ray and laboratory charges as explained on page 28 and newborn care as explained on page 32.
- Expenses connected with treatment of weak, strained or flat feet or instability or imbalance of the feet, metatarsalgia or bunions, except open cutting operations.
- Doctors' services for treatment of superficial lesions of the feet including corns, calluses and hyperkeratoses.
- Services, supplies, testing and other charges related to In-Vitro Fertilization.
- Charges for educational testing, training, and assessments for mental capacity.
- Charges in connection with speech therapy for education or training. (See page 33.)
- Charges by a veterans, military, public health service or other federal health care facility, or paid by a government agency. Also, charges by a charitable hospital or organization are specifically excluded.
- Charges incurred for accommodations (including room and board and other institutional services) and nursing services primarily to assist the person in daily living activities. These charges will be considered custodial care

and are not payable. This limitation also applies to individuals receiving medical service that is merely maintenance care that cannot reasonably be expected to substantially improve a medical condition.

- Charges for medical care or supplies incurred as a result of injury if you or your dependent engage in an illegal action, or are the aggressor in a dispute.
- Charges for dietary instruction unless prescribed for diabetes.
- Charges incurred for services rendered by a provider who does not meet the Plan's definition of a doctor or provider of services as described on page 13.
- Charges for non-medical services and equipment – even if prescribed – such as athletic or health club dues, environmental control equipment, air conditioners, air purifiers, humidifiers, exercycles, treadmills, waterbeds, bathroom safety equipment, etc. (See page 34.)
- Charges for personal expenses during hospitalization such as hospital comfort kits, hospital admission kit, telephone, television, etc.
- Charges incurred prior to the effective date or after the termination date of this coverage.
- Acupuncture when performed by anyone other than a doctor.
- Treatment given at a medical facility maintained by FMC, or provided through any other Plan paid for or sponsored by the company.
- Treatment given by a member of your immediate family or your spouse's immediate family, i.e, parent, sister, brother.
- Any sales or other taxes, or any service or interest charges.
- Charges for the completion of claim forms or preparation of medical reports.

- Charges for vocational evaluations.
- Services or supplies that are not described in this booklet.

## CLAIMING BENEFITS

### Evidence of Coverage

You will receive an identification card on the effective date of your medical coverage. The card identifies you as a member of this Plan. When you are admitted to a hospital, present this card as evidence of your coverage.

### Making a Claim

Often you'll know in advance when you, or a covered family member requires hospitalization. Before going in, it's a good idea to talk with the Human Resources Department about how claims are processed under our Plan. They will provide you with forms for filing your claim.

In general, to file a claim you must complete the original form and return it to your Human Resources Department, or to your direct claims administration office, along with your itemized bills.

The employee's social security number must be on the original claim form. If the number does not appear, the Claim Administrator will not process the claim.

You must also be able to provide proof of all expenses – including those that apply to the deductible. Be sure to keep all bills and receipts, and make certain they are itemized and contain the following information:

- your name (or the name of the patient if not you)

- the name, address and telephone number of the provider
- the nature of the illness – diagnosis must be shown
- the type of service performed
- the date the service was provided
- the amount charged

The Claim Administrator requires original bills and receipts. They will pay your claims as soon as they are satisfied that your expenses are covered by the Plan and your proof is valid.

Certain benefit provisions have limits and lifetime maximums. As a consumer, you should keep a record of paid benefits. The Claim Administrator, upon request, can furnish you with an up-to-date benefit status. It is not the responsibility of either the Claim Administrator or FMC to notify you of impending benefits that will exceed Plan limits or maximums. If you do not submit a claim within one year of the date the expenses were incurred, there will be no coverage for that particular expense.

Claims are subject to routine auditing for fraud, duplicate coverage and subrogation.

### COORDINATION OF BENEFITS

If you or a covered member of your family are eligible to receive benefits under another group medical plan, Health Maintenance Organization (HMO), government plan, or by "no-fault" automobile insurance which provides medical coverage, you may be eligible for benefits from those Plans and your FMC Plan. In the case of

coverage by "no-fault" automobile insurance, FMC will pay covered expenses not paid for by no-fault insurance.

The benefits paid from this Plan will be coordinated to cover up to – but no more than – 100% of the benefits allowable under this Plan.

One Plan pays first. This is determined as follows:

- The Plan with no coordination of benefits provision pays before a Plan that has a coordination provision.
- The Plan covering the person as an employee pays first.
- In situations of divorce, separation, and/or divorce and remarriage, benefits for a child's medical expenses will be payable as follows:

1. If a court decree has established financial responsibility for medical expenses for the child, the Plan of the parent with such financial responsibility pays first, the Plan of the other natural parent pays second, and the Plan covering the spouse of the parent with financial responsibility (the step-parent) pays third.

2. If there is no court decree which establishes financial responsibility for the child's medical expenses, the Plan of the parent who has custody of the child pays first, the Plan covering the spouse of the parent who has custody (the step-parent) pays second, and the Plan of the natural parent without custody pays third.

- For children's expenses, the Plan of the parent having the earlier birthday in the calendar year pays first. For example: if the father's birthday is July 2 and the mother's birthday is March 27, the mother's plan is primary for the couple's dependent children. If the father's and mother's birthdays are on the same day, the plan covering a parent longer is the primary plan.

- The Plan that covers the claimant as an active employee pays before a Plan covering the claimant as a retired or laid-off employee.



Usually, by this time a priority for paying has been established, but if it has not:

- The Plan that has covered the claimant for the longest time pays first.

The plan paying first, called the primary plan, pays up to its maximum benefits. The other plan or plans pay as many of the unpaid charges as are allowed, according to each plan's provisions. If the expense is subject to a deductible, both plan's deductibles must be met before benefits are payable.

You will never receive less if you are covered under two or more medical Plans than you would if you were covered by this Plan alone. However, the most your FMC Health Care Plan will pay is an amount that would bring benefits to FMC levels. For example, if your spouse is covered by another plan and that plan pays an amount equal to or greater than the FMC Plan, FMC would make no additional payment. (See pages 46-48 for examples of how Coordination of Benefits works.)

To avoid lengthy delays in processing your claim, it is important that you file it properly when Coordination of Benefits applies. If your spouse or eligible family member is covered under another employer's plan so that FMC has secondary responsibility as described above, submit the application to the other employer first. Then, submit your application to FMC in the normal manner with a copy of the payment statement from the other plan so that the extent of FMC's secondary responsibility can be determined. If the Claim Administrator for the FMC Plan pays more than it should when another Plan is involved,

it will request a repayment of benefits from the other plan or from you.

## EXAMPLES OF COORDINATION OF BENEFITS

### ABC Company Has Lower Benefit Level Than FMC

Let's assume your spouse, who is employed by ABC Company, incurs eligible out-patient doctor's charges of \$750. In this case, ABC Company, your spouse's employer, is "primary" and the FMC Plan is "secondary".

Let's suppose the ABC Company's Plan (primary payor) pays for 80% of the eligible expenses (after the deductible) and the FMC Plan (secondary payor) pays 90% of eligible expenses (after the deductible).

Here's how your Coordination of Benefits provision works.

Step 1	ABC Company	FMC Corporation
Total eligible expenses	\$ 750	\$ 750
Subtract the deductible	-150	-150
	<u>\$ 600</u>	<u>\$ 600</u>
Rate of benefit payment	x 80%	x 90%
Primary payor pays	<u>\$ 480</u>	<u>\$ 540*</u>

(\*FMC would pay this amount if it were the primary payor.)

#### STEP 2

From the expenses that FMC would normally cover - \$ 540  
 FMC subtracts what ABC Company (primary payor) pays - -480  
 And FMC pays the difference \$ 60

Therefore, your spouse would receive a total of \$540 - \$480 comes from ABC Company, the primary payor and \$60 comes from FMC. You and your spouse would be financially responsible for paying out-of-pocket the \$210 balance due (\$750 less \$540) to the physician.

#### ABC Company Has Higher Benefit Level Than FMC

Let's assume your spouse, who is employed by ABC Company, incurs eligible out-patient doctor's charges of \$750. In this case, ABC Company, your spouse's employer, is "primary" and the FMC Plan is "secondary".

Let's suppose the ABC Company's Plan (primary payor) pays for 95% of the eligible expenses (after the deductible) and the FMC Plan (secondary payor) pays 90% of eligible expenses (after the deductible).

Here's how your Coordination of Benefits provision works.

	ABC Company	FMC Corporation
Total eligible expenses	\$ 750	\$ 750
Subtract the deductible	-150	-150
	<u>\$ 600</u>	<u>\$ 600</u>
Rate of benefit payment	x 95%	x 90%
Primary payor pays	<u>\$ 570</u>	<u>\$ 540*</u>

(\*FMC would pay this amount if it were the primary payor.)

In this example, your spouse would receive a total of \$570 from ABC Company. Since ABC Company pays a higher benefit than the FMC Health Care Plan, FMC will make no additional payment.

#### ABC Company Has Same Benefit Level As FMC

Let's assume your spouse, who is employed by ABC Company, incurs eligible out-patient doctor's charges of \$750. In this case, ABC Company, your spouse's employer, is "primary" and the FMC Plan is "secondary".

Let's suppose the ABC Company's Plan (primary payor) pays for 90% of the eligible expenses (after the deductible) and the FMC Plan (secondary payor) pays 90% of eligible expenses (after the deductible).

Here's how your Coordination of Benefits provision works.

	ABC Company	FMC Corporation
Total eligible expenses	\$ 750	\$ 750
Subtract the deductible	-150	-150
	<u>\$ 600</u>	<u>\$ 600</u>
Rate of benefit payment	x 90%	x 90%
Primary payor pays	<u>\$ 540</u>	<u>\$ 540*</u>

(\*FMC would pay this amount if it were the primary payor.)

In this example, your spouse would receive a total of \$540 from ABC Company. Since ABC Company pays the same benefit as the FMC Health Care Plan, FMC will make no additional payment. You and your spouse would be financially responsible for paying out-of-pocket the \$210 balance due (\$750 less \$540) to the physician.

### No-Fault

In some states with no-fault motor vehicle coverage, the carrier is the primary insurer in these jurisdictions. All medical expenses related to an accident must be submitted to the carrier and not the FMC Health Care Plan. Eligible expenses not paid for by no-fault insurance will be paid by the FMC Plan.

### Third Party Reimbursement

If you or an eligible family member incur medical or dental expenses for an illness or injury because of the fault of another person, that person is responsible for any

hospital or medical expenses which may result. Collecting this money may take several months. In such cases, your FMC Health Plan will pay the appropriate benefits. However, the FMC Plan has the right to seek repayment of those benefits from the party that causes the illness or injury. Automobile accident injuries or personal injury suffered on another's property are examples of cases subject to this provision.

The FMC self insured benefit program is automatically assigned the right of action against third parties in any situation in which benefits are paid to employees or their dependents. If you bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled you must reimburse the Plan for the benefits provided. You are obligated to avoid doing anything which would prejudice the Plan's rights of reimbursement, and you are required to sign and deliver documents to evidence or secure those rights. Unless you sign the Company's "third party reimbursement form," the Claims Administrator will not process any claim where there is possible liability on behalf of a third party.

### Medicare Coverage if You Are Totally Disabled

If you or any eligible family member meets the disability eligibility requirements for Medicare, the FMC Health Care Plan benefits will be reduced by the amount Medicare pays, or would have paid if Medicare coverage had been in effect.



Medicare benefits are generally available to someone who has been receiving Social Security disability benefits for two consecutive years.

If you or any eligible family member becomes eligible for Medicare, you must apply for both Parts A and B. Your Human Resources Representative or your local Social Security office can help you complete the application. **If you do not apply when you are eligible, your FMC Health benefits will be reduced as though you had Medicare coverage.**

When the FMC Health Plan is reduced by Medicare, the Coordination of Benefits rules are not applied unless there is coverage by another group health plan.

### Quality Care Review

The Health Plan is designed to provide you and your family with quality medically necessary care. A quality care review system helps assure that the Plan meets this goal without paying unreasonable or unnecessary expenses.

In the unusual event that a question arises regarding the medical necessity of any treatment, professional medical evaluators – including physicians and specialists – may be asked to study the situation. After careful review, if they determine that the treatment was unnecessary, or outside the bounds of generally accepted medical practices in the United States, it may not be covered.

### Alternative Treatment May Be Considered

Medical claims may be reviewed to assess the cost-effectiveness of ongoing treatments, services and supplies. This is done to assure that the Plan covers the reasonable expenses which are medically necessary to provide quality care. Although it's uncommon, it may be determined that a treatment, service or supply is available on a more cost-effective basis. This might include such things as the use of home nursing visits in place of a prolonged recuperation in a hospital or other facility, or the purchase or rental of equipment which is often available only in a hospital. In cases such as these, the Plan may cover only the less costly alternative.

### HOW LONG COVERAGE CONTINUES

In This Situation:	This Happens to Your Coverage:
You are on disability leave of absence.	Coverage continues for you and your dependents for the length of your leave, provided you continue to pay your regular contributions.
You are on military leave of absence (excluding summer training).	Coverage ends for you and your dependents on the date you terminate. Coverage can be continued for you and your dependents. See the section, "Continuation of Coverage."

In This Situation:	This Happens to Your Coverage:
You are on a personal or education leave of absence.	Coverage may continue for you and your dependents for the length of your leave, provided you pay the entire cost. Please see the section, "Continuation of Coverage."
You terminate employment prior to retirement or transfer to an employee group the plan does not cover.	Coverage ends for you and your dependents on the date you terminate. If you desire continued health insurance protection after your coverage ceases, see the section, "Continuation of Coverage."
You retire from the Company.	Coverage ends for you and your dependents on the date you terminate. Coverage can be continued for you and your dependents if you so elect. See the section "Medical Coverage After Retirement."
A dependent becomes ineligible.	Coverage ends on the date the dependent becomes ineligible. If a dependent full-time student becomes ineligible due to the age 23 limitation, coverage continues until the end of the academic semester in which the student attained age 23. Coverage can

In This Situation:	This Happens to Your Coverage:
	be continued for your dependent. See the section, "Continuation of Coverage."
You die.	Continued coverage for dependents is based upon the deceased employee's age and service at time of death. There is no permanent coverage available for dependents unless the deceased employee was age 40 or older <i>and</i> had 10 or more years of credited service. The following outlines coverage continuation for dependents:  <b>Age 55 or Older With 10 or More Years of Credited Service -</b> Coverage continues on the same basis as if the deceased had been a retiree. (See section headed, "Medical Coverage After Retirement".) <b>Age 40 to 54 with 10 or More Years of Credited Service -</b> Coverage can be continued for your dependents (See the section, "Continuation of Coverage"). Coverage under the FMC Retiree Health Care Plan is not available until the first of the month following the deceased employee's fifty-fifth birthday. At that time,

In This Situation:	This Happens to Your Coverage:
You die. (cont'd)	<p>coverage for eligible dependents continues on the same basis as if the deceased had been a retiree. (See section headed, "Medical Coverage After Retirement" for explanation of retiree coverage.)</p> <p><b>All Others -</b> Coverage can be continued for your dependents (see the section, "Continuation of Coverage").</p> <p>For those dependents covered under the Retiree Health Care Plan, coverage ceases upon the spouse's death. Coverage for dependent children continues until the spouse dies or the children no longer qualify as dependents, whichever is earlier.</p>
The plan is terminated or changed so that it no longer covers your employee group.	Coverage for you and your dependents ends immediately.

### Continuation of Coverage

If you or your eligible dependents lose coverage under the FMC Health Care Plan, health care coverage can be continued for you and your eligible dependents under

certain circumstances, provided you pay the full premium for this coverage.

Coverage for you and your dependents may be continued for up to 18 MONTHS if you:

1. Terminated or were terminated for reasons other than gross misconduct;
2. became ineligible for coverage because you experienced a reduction in hours worked.

Coverage for your eligible dependents may be continued for up to 36 MONTHS under the following circumstances:

1. If you become divorced or legally separated from your spouse;
2. if you die;
3. if you have dependent children who are covered under the Plan and who reach the Plan's limiting age (age 19, or age 23 for a full-time student);
4. your spouse and your dependents who are ineligible for Medicare if you should elect Medicare coverage and decline FMC's Health Care Plan.

Should you voluntarily terminate, are terminated, experience a reduction in hours or elect Medicare coverage instead of FMC's Health Care Plan, FMC will notify you within 14 days of the event as to the terms and duration of coverage. At the end of this notification period, the 60 day election period commences. During this time period, you can decide whether or not you wish to elect to continue FMC's Health Care Plan. In any event, you must make a decision by the end of this 60 day period. Should you decide to elect continued coverage under the FMC plan, you will have another 45 days in which to pay the appropriate premiums for the coverage. Your premiums are payable on a monthly basis.



Should you become either divorced or legally separated, or have an eligible dependent that reaches the age limit specified in the Plan, you must notify FMC in writing within 60 days after any of the said events take place. FMC will then provide information within the same time frame as indicated above.

If you do not notify FMC of status changes within the 60 day period, or if you do not pay your premiums when they are due, you will forfeit your continued coverage under the FMC Health Care Plan. There will be no exceptions to the 60 day notification period.

Your continued coverage under the FMC Health Care Plan will also end when the first of these events occur:

1. The FMC Health Care Plan terminates;
2. the end of the period allowed for continuation coverage;
3. the date you or your dependent become insured under another group health plan;
4. the date you or your dependents become eligible for Medicare.

### **Medical Coverage After Retirement**

When you retire you can elect to participate in the FMC Health Care Plan for retirees. This Plan provides the same health care benefits you had as an active employee (described in the subsequent pages of this section of your handbook).

When you, your spouse or eligible dependent attain age 65, benefits will be coordinated with Medicare coverage; thus you are required to enroll and pay the required

premiums for Medicare Part "B". The FMC Health Care Plan begins paying benefits after Medical Parts A and B have paid the maximum benefit allowed. Thus, if you are not enrolled in Medicare Parts A and B, you are responsible to pay the charges that Medicare would normally cover.

You are required to pay monthly contributions for your health coverage. From time to time, depending upon Plan experience, the premium will be adjusted (usually upward). You will be notified, in advance, of any premium increase or decrease. Your Human Resources Representative can provide you with the current contribution rates.

Several items of importance concerning health care coverage for retirees include:

1. If you do not enroll yourself or any other eligible dependents in the FMC Retiree Health Plan when first eligible (following last day of active work), you permanently forfeit the right to enter the Plan.
2. If you enroll in the FMC Retiree Health Care Plan at retirement, but later drop out, you permanently forfeit the right to re-enter the Plan.
3. If you enroll in the FMC Retiree Health Care Plan at retirement and later marry, your new spouse is eligible for Plan coverage as long as enrollment is within 31 days of the marriage. Dependents of the new spouse are not eligible for coverage.
4. If you reside in a foreign country and have attained age 65, your benefits under this Plan will be calculated as if you were eligible and receiving both Medicare Parts "A" and "B". In no case, if you are age 65 or older, will the FMC Health Care Plan provide coverage without coordination for Medicare A and B regardless of eligibility.

### Claim Fraud

The FMC Health Plan is intended to provide eligible benefits to eligible participants. Intentional false, incomplete or misleading information on enrollment cards and claim submissions are subject to disciplinary action. In addition, the company may terminate your employment and legally recover monies obtained fraudulently.

### SITUATIONS THAT COULD AFFECT PLAN BENEFITS

1. FMC expects and intends to continue the Health Care Plan indefinitely. However, the Company reserves the right to amend or terminate the Plan at any time and for any reason. If the Plan is amended or terminated, you and other active and retired employees may not receive benefits as described in other sections of this booklet. You may be entitled to receive different benefits, or benefits under different conditions. However, it is possible that you will lose all benefit coverage. This may happen at any time, even after you retire, if the Company decides to terminate the Plan or your coverage under the Plan. In no event will you become entitled to any vested rights under this Plan.

2. If you do not apply for benefits or provide the necessary claim information, no benefits can be paid.

3. If you do not make required contributions when they are due, Plan membership will end. At that time, you will be permanently barred from re-entering the Plan; however, you will be eligible to continue coverage for you and you dependents as described in the "Continuation of Coverage" section.

### OTHER INFORMATION ABOUT THE PLAN

1. FMC Corporation and the Claim Administrator keep all Plan records on a Plan-year basis, starting January 1 and ending December 31.

2. Claim denial appeal provisions are discussed in detail under the section titled "Additional Information" in this handbook.

3. The health care plan is funded through a contract with the Claim Administrator, Equicor.

4. The benefits outlined in this Summary Plan Description cannot possibly be conclusive due to space limitations. As a result, the Claim Administrator may invoke special limitations on eligible expenses, subject to generally accepted insurance industry practices.

5. This Plan is filed with the U.S. Department of Labor under Plan Number PN 540 and the Plan name FMC Salaried Health Plan.

**EXHIBIT B**

CYNTHIA ANN HOLLIDAY,	*	IN THE COURT OF
A MINOR, BY GERALD S.	*	COMMON PLEAS
HOLLIDAY, HER GUARDIAN,	*	INDIANA COUNTY,
Plaintiff	*	PENNSYLVANIA
	*	
VS.	*	CIVIL ACTION
	*	IN LAW
	*	
ROBERT SCOTT LYONS,	*	NO. 535
Defendant	*	C.D. 1987
	*	
	*	JURY TRIAL
	*	DEMANDED

(Filed April 21, 1987)

**NOTICE**

You have been sued in Court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this complaint and notice are served, by entering a written appearance personally or by attorney and filing in writing with the Court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the Court without further notice for any money claimed in the complaint or for any claim or relief requested by the Plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE OR KNOW A LAWYER, THEN YOU SHOULD GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP:

Count Administrator  
4th Floor, Courthouse  
Indiana, PA 15701  
(412) 465-2663

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CYNTHIA ANN HOLLIDAY, A MINOR, BY GERALD S. HOLLIDAY, HER GUARDIAN,	* IN THE COURT OF * COMMON PLEAS * INDIANA COUNTY, * PENNSYLVANIA
Plaintiff	* CIVIL ACTION
VS.	* IN LAW
ROBERT SCOTT LYONS,	* NO. _____
Defendant	* C.D. 1987
	* JURY TRIAL * DEMANDED

### COMPLAINT

1. The Plaintiff, Cynthia Ann Holliday is a minor, having been born on September 13, 1971, and resides in Indiana County at 1569 Church Street, Indiana, Pennsylvania 15701.

2. Gerald S. Holliday is an adult individual who is the natural father and guardian of Cynthia Ann Holliday and who resides in Indiana County at 1569 Church Street, Indiana, Pennsylvania 15701.

3. The Defendant, Robert Scott Lyons, is a minor, having been born on February 16, 1970, and resides in Indiana County at 941 McHenry Road, Indiana, Pennsylvania 15701.

4. The facts and occurrences hereinafter stated took place on January 16, 1987, at or about 2315 hours in White Township, Indiana County, Pennsylvania on Ben Franklin Road.

5. At the aforesaid time and place, Plaintiff was lawfully riding as a passenger in a 1977 Mercury Marquis, vehicle Title number 29791530, being operated by Robert Scott Lyons, Defendant.

6. At the aforesaid time and place, Defendant, Robert Scott Lyons, lost control of the vehicle he was operating, crossed the line of the roadway and struck head on, a vehicle coming in the opposite direction.

7. The negligence and carelessness of the Defendant, all of which is the proximate cause of the Plaintiff's injuries hereinafter alleged, consisted of:

- (a) Operating his vehicle at an excessive rate of speed under the circumstances.
- (b) Failing to have his vehicle under proper and adequate control.
- (c) Failing to observe the oncoming vehicle traveling in the opposite direction.
- (d) Failing to keep a reasonable lookout for other vehicles lawfully on the road.
- (e) Failing to drive at a speed and in a manner that would allow him to stop within an assured clear distance ahead and prevent him from crossing the center line of the roadway.
- (f) Operating a motor vehicle while under the influence of alcohol to a degree which rendered him incapable of safe driving.
- (g) Otherwise operating said vehicle in a careless, reckless and negligent manner and in a manner violating the Motor Vehicle Code of the Commonwealth of Pennsylvania.

8. The accident was caused by the negligence and recklessness of the Defendant, Robert Scott Lyons, and in no way was caused by the Plaintiff.

9. As a result of the aforementioned accident, Plaintiff, Cynthia Ann Holliday, suffered severe, permanent,

and disabling injuries which include, but are not limited to:

- (a) Loss of Four teeth
- (b) Fractured left hand
- (c) Collapsed lung
- (d) Severe head lacerations
- (e) Significant encephalopathy secondary to a severe head injury
- (f) Organic brain syndrome secondary to severe head injury
- (g) Severe left subdural hematoma
- (h) Midline shift to the right and effacement of the occipital horn
- (i) Motor cognitive, and psychological dysfunction secondary to a severe head injury
- (j) Depressed skull fracture

10. As a result of her aforementioned injuries, Plaintiff, Cynthia Ann Holliday, has undergone in the past and will in the future, continue to undergo great pain and suffering.

11. As a result of her aforementioned injuries, Plaintiff, Cynthia Ann Holliday, has suffered a permanent disability and a permanent impairment of her earning power and capabilities.

12. As a result of her injuries, Plaintiff, Cynthia Ann Holliday, has suffered a permanent diminution in the ability to enjoy life and life's pleasures and will require future care and services.

13. As a result of her injuries, Plaintiff, Cynthia Ann Holliday, and her guardian, have incurred other medical

expenses which exceed sums recoverable under 75 PA. CS 1711. The amount of said losses which exceed benefits recoverable under 75 PA. CS 1711 are in excess of \$100,000, and are continuing.

WHEREFORE, Plaintiff, Cynthia Ann Holliday, a minor, by Gerald S. Holliday, her Guardian, demands judgment against the Defendant, Robert Scott Lyons, in the amount in excess of Ten Thousand Dollars (\$10,000.00) and in excess of the amount requiring compulsory arbitration.

/s/ Thomas G. Johnson  
Thomas G. Johnson, Esquire  
Attorney for Plaintiff

COMMONWEALTH OF \*  
PENNSYLVANIA \*  
\* ss.  
COUNTY OF INDIANA \*

Before me, the undersigned authority, personally appeared Gerald S. Holliday, natural father and guardian of Cynthia Ann Holliday, the Plaintiff in the within action, who being by me duly sworn according to law, deposes and says that the averments contained in the foregoing Complaint are true and correct on personal knowledge as to those facts of which he has personal knowledge, and on information and belief as to those facts of which he does not have personal knowledge.

/s/ Gerald S. Holliday  
Gerald S. Holliday,  
natural father and guardian  
of Cynthia Ann Holliday

Sworn to and subscribed before  
me this 20th day of April, 1987.

/s/ Denise Miller-Buzzinotti

DENISE MILLER-

BUZZINOTTI

Notary Public

Indiana County, Indiana, PA

Commission Expires

July 9, 1990

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A. HARKLEROAD by handing to him personally a true and correct copy of the petition for interpleader and making known to him the contents thereof at 109 Royal Garden St., Indiana, White Twp., Indiana County, PA.

September 12, 1987 at 2:25 P.M. served the within Petition for Interpleader upon EDWARD HOWELL by handing to him personally a true and correct copy of the petition for interpleader and making known to him the contents thereof at 492 East Pike, Indiana, White Twp., Indiana County, PA.

September 15, 1987 at 10:30 A.M. served the within Petition for Interpleader upon DOUGLAS B. BUSH by handing to him personally a true and correct copy of the petition for interpleader and making known to him the contents thereof at 51 S. 14th Street, Indiana Borough, Indiana County, PA.

September 16, 1987 at 1:45 P.M. served the within Petition for Interpleader upon JANE FULMER by handing to Glenn Miller, person in charge at time, a true and correct copy of the petition for interpleader and making known to him the contents thereof at R.D. #1, Creekside, Washington Twp., Indiana County, PA.

So answers,

John R. Gondal

Sheriff, Indiana County

By /s/ Norman Bruce Preite

Norman Bruce Preite,  
Deputy

Sworn to and subscribed before  
me this 17th day of September,  
1987.



/s/ Linda J. Moore  
 Prothonotary, Indiana County  
 MY COMMISSION EXPIRES  
 (illegible) MONDAY IN JAN-  
 UARY 1988

Costs: 50.00

IN THE COURT OF COMMON PLEAS  
 OF INDIANA COUNTY,  
 PENNSYLVANIA  
 CIVIL DIVISION

---

CYNTHIA ANN HOLLIDAY, a  
 minor, by  
 GERALD S. HOLLIDAY, her  
 guardian,

Plaintiffs

-vs-

ROBERT SCOTT LYONS,

Defendant

---

**PETITION FOR INTERPLEADER**

---

STEWART, BELDEN AND BELDEN  
 ATTORNEYS AT LAW

---

BELDEN BUILDING  
 117 NORTH MAIN STREET  
 GREENSBURG, PENNSYLVANIA 15601

As Exhibit C to the Complaint, Plaintiff attached copies of  
 75 Pa. Cons. Stat. Ann. §§ 1711-1724, 1731 (Purdons 1984).

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As Exhibit D to the Complaint, Plaintiff attached copies  
 of 75 Pa. Cons. Stat. Ann. §§ 1701-1704 (Purdons 1984).

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IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC CORPORATION,  
A CORPORATION,

Plaintiff

VS.

CYNTHIA ANN HOLLIDAY,  
AN INDIVIDUAL,

Defendant

\*  
\*  
\*  
\* CIVIL ACTION  
\* NO. 88-1098  
\*  
\*  
\*

ANSWER AND AFFIRMATIVE DEFENSES

Defendant, Cynthia Ann Holliday, by her Attorney, Thomas G. Johnson, comes forth and hereby opposes the prayers for declaratory relief and requests that the complaint be dismissed and, in support thereof, states as follows:

ANSWER

1. The allegations set forth in paragraphs 1, 3, 4, 5, 9, 10, 11, 12, 14, 17, 18, 25, 26, 28, and 29 are admitted.

2. The allegations set forth in paragraph 2 of the complaint are denied in so far as Cynthia Ann Holliday is not an individual but rather an unemancipated minor.

3. The allegations set forth in paragraph 6 of the complaint are denied. To the contrary, FMC is not the fiduciary of the health plan and not therefore a proper party to bring this action.

4. The allegations set forth in paragraph 7 of the complaint are admitted in part and denied in part. It is

admitted that a health plan is filed with the U.S. Department of Labor. It is denied that such plan is self-funded and falls within the purview and qualifications of ERISA.

5. Denied. The allegations set forth in paragraph 8 of the complaint are denied. It is specifically denied that the health plan qualifies as an employee welfare benefit plan within the meaning of 29 U.S.C. 3 of ERISA. It is further denied that ERISA preempts state law as to prohibiting subrogation for co-pay medical providers.

6. Denied. The allegations set forth in paragraph 13 of the complaint are denied. It is specifically denied that the health plan provided approximately \$105,000.00 in benefits to cover medical expenses incurred by Ms. Holliday. To the contrary, if the health plan paid such a sum of money such payment amounts to overpayment of benefits, not subject to subrogation, and contrary to the provisions of the Pennsylvania Catastrophic Loss Fund.

7. The allegations set forth in paragraph 15 of the complaint are admitted in part and denied in part. It is admitted that the health plan provides that claims paid pursuant to the plan are subject to subrogation. It is denied that such health plan is entitled to subrogate the third party tort recovery of Ms. Holliday for the reason that such right is in violation of the Pennsylvania Motor Vehicle Financial Responsibility Act of 1984, 75 Pa. C.S.A. 1701 *et seq.*

8. That allegations set forth in paragraph 16 of the complaint are denied. It is denied that the fiduciary of the health plan has a responsibility to seek subrogation since such right is in direct violation of the Pennsylvania Motor Vehicle Financial Responsibility Act of 1984. It is also

specifically denied that the taking of a tort settlement from a catastrophically injured minor is not consistent with the orderly administration of the health plan and in accordance with the ERISA law and public policy.

9. The allegations set forth in paragraph 19 of the complaint are admitted in part and denied in part. It is admitted that the health plan has made repeated demands to subrogate and that the Attorney for Ms. Holliday has refused to accede to FMC exercise of its subrogation rights. It is denied that the only reason the Attorney for Ms. Holliday has denied such right is under Section 1720 of the Act. It is specifically asserted that in addition to Section 1720, other reasons for such denial are formed in affirmative defenses contained herein.

10. The allegations set forth in paragraph 20 of the complaint are denied for the reason that the same are arguments and inaccurate conclusions of law.

11. The allegations set forth in paragraph 21 of the complaint are denied for the reason that the same are arguments and inaccurate conclusion of law.

12. The allegations set forth in paragraph 22 of the complaint are denied for the reason that the same are arguments and inaccurate conclusion of law.

13. The allegations set forth in paragraph 23 of the complaint are denied for the reason that the same are arguments and inaccurate conclusion of law.

14. The allegations set forth in paragraph 24 are denied for the reason that the health plan is not a self-insured plan as contemplated under ERISA.

15. The allegations set forth in paragraph 27 of the complaint are denied. On the contrary, it is averred that Sections 1711, 1712, and 1715 do not specifically limit their coverage to policies provided by an insurer issuing or delivering liability insurance policies covering any motor vehicle of the type required to be registered under the Act. Any insurer who provides medical benefits are subject to the Act.

16. The allegations set forth in paragraph 30 of the complaint are denied. Sections 1711, 1712, 1715, and 1719 do specifically refer to, include, and govern health plans such as FMC's.

17. The allegations set forth in paragraph 31 of the complaint are denied for the reason that the same are arguments and inaccurate conclusions of law.

## AFFIRMATIVE DEFENSES

### FIRST DEFENSE

18. The complaint fails to set forth a cause of action upon which relief can be granted.

### SECOND DEFENSE

19. The Court should exercise its discretion and decline to grant any declaratory relief.

### THIRD DEFENSE

20. The Court lacks jurisdiction and the action should be dismissed because Plaintiff, FMC, failed to join necessary and indispensable parties.



## FOURTH DEFENSE

21. The complaint should be dismissed because FMC has improperly brought a minor into said action, and excluded necessary and indispensable parties.

## FIFTH DEFENSE

22. FMC should, in the alternative, not be entitled to subrogate against the third party tort claim of Ms. Holliday unless, and until settlement from the negligent tortfeasor is determined to amount to compensation for 100% of her damages.

## SIXTH DEFENSE

23. FMC, in the alternative, should only be entitled to subrogate a percentage of its claim equal to the percentage of actual tort recovery in relationship to total damages proven by Ms. Holliday.

## SEVENTH DEFENSE

24. The complaint for declaratory judgment should be dismissed because the Pennsylvania Motor Vehicle Financial Act of 1984, 75 Pa. C.S.A. 1701 *et seq.* specifically prohibits the right of subrogation to a medical provider who tenders benefits on a coordination of benefits basis.

## EIGHTH DEFENSE

25. The complaint for declaratory judgment should be dismissed because the payment of \$105,000.00 medical

benefits was contrary to the provisions of the Catastrophic Loss Trust Fund, 75 Pa. C.S.A. 1761 *et seq.*

## NINTH DEFENSE

26. The complaint for declaratory judgment should be dismissed because the claim for relief stated therein is contrary to Rule 2039 (A) (2) of the Pennsylvania Rules of Civil Procedure.

## TENTH DEFENSE

27. The complaint for declaratory judgment should be dismissed as the subrogation requested is void as against public policy.

## ELEVENTH DEFENSE

28. The complaint for declaratory judgment should be dismissed as the subrogation requested works an undue hardship and amounts to a forfeiture without due process of law.

WHEREFORE, Defendant, Cynthia Ann Holliday, respectfully requests that the complaint be dismissed, declaratory relief be denied, and that counsel fees and costs be awarded to Defendant.

JURY TRIAL DEMANDED.

Respectfully submitted,

---

Thomas G. Johnson, Esquire  
The Daugherty House  
824 Church Street

Indiana, Pennsylvania 15701  
(412) 463-0226

Counsel for Defendant,  
Cynthia Ann Holliday

### CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document was served by first class, postage-prepaid mail this 21st day of July, 1988, at follows:

Charles Kelly, Esquire  
Kirkpatrick and Lockhart  
1500 Oliver Building  
Pittsburgh, Pennsylvania 15222

By: /s/ Thomas Johnson  
Thomas G. Johnson, Esquire  
Attorney for Defendant,  
Cynthia Ann Holliday

### IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC CORPORATION,	)	
a corporation	)	
Plaintiff,	)	Civil Action
	)	No. 88 1098
v.	)	
CYNTHIA ANN HOLLIDAY,	)	
an individual,	)	
Defendant.	)	

### MOTION OF PLAINTIFF, FMC CORPORATION, FOR SUMMARY JUDGMENT

AND NOW COMES Plaintiff, FMC Corporation, by its attorneys, Kirkpatrick & Lockhart, and respectfully moves this Court, pursuant to Rule 56(a) of the Federal Rules of Civil Procedure, for the entry of summary judgment in favor of FMC Corporation, stating as follows:

1. FMC Corporation ("FMC") has established and maintains an employee welfare benefit plan within the meaning of ERISA Sections 3(1) and 4(a), 29 U.S.C. Sections 1002(1) and 1003(a)(1). The plan is known as the FMC Salaried Health Care Plan ("Health Plan"). The Health Plan is self insured.

2. Gerald S. Holliday ("Mr. Holliday"), the father and legal guardian of Cynthia Holliday ("Ms. Holliday"), is an employee of FMC and at all times relevant to this action subscribed to the Health Plan. Ms. Holliday is a dependent of Mr. Holliday and a beneficiary of the Health Plan.

3. On January 16, 1987, Ms. Holliday sustained serious injuries in an automobile accident and required extensive and intensive medical treatment. FMC, on Ms. Holliday's behalf, paid in excess of \$67,000 in medical benefits.

4. On April 20, 1987, Mr. Holliday, on behalf of Ms. Holliday, commenced in the Court of Common Pleas for Indiana County, Pennsylvania, a civil action (the "Indiana County action") against the driver of the vehicle who was responsible for the accident in which Ms. Holliday was injured. That action is pending.

5. The Health Plan provides, *inter alia*, that FMC's self insured benefit program is automatically assigned the right of action a subscriber to the Health Plan brings against third parties in any situation in which benefits are paid to employees or their dependents.

6. FMC, after the Indiana County action was commenced, notified counsel for the Hollidays of its intention to exercise its subrogation rights. Counsel, Thomas G. Johnson, has objected to FMC's exercise of its subrogation rights, claiming that the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 (the "Law") precludes self-insured medical providers, such as FMC, from exercising such rights.

7. FMC disagrees and now seeks the entry of summary judgment in its favor for two basic reasons:

First, the Employee Retirement Income Security Act ("ERISA") preempts the Law's anti-subrogation clause. The U.S. Supreme Court case of *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), and its progeny,

firmly establish that a state statute regulating insurance will be preempted to the extent it is applied to a self-insured employee welfare benefit plan, such as the Health Plan. (For detailed discussion see accompanying Memorandum of FMC Corporation In Support of Motion for Summary Judgment).

Second, a careful reading of the Law demonstrates that the Pennsylvania Legislature did not intend, in drafting the Law, to deny self-insured medical providers the right to exercise subrogation rights. (See accompanying FMC Memorandum In Support).

WHEREFORE, for the reasons stated above and in the accompanying Memorandum In Support, FMC respectfully requests that this Court order the defendant and her counsel to honor FMC's contractually-provided right of subrogation and cooperate with FMC's exercise of such right. A proposed Order of Court is attached hereto pursuant to Local Rule 4(a)(2).

Respectfully submitted,

DATE:

/s/ Charles Kelly  
H. Woodruff Turner, Esquire  
Charles Kelly, Esquire  
Kirkpatrick & Lockhart  
1500 Oliver Building  
Pittsburgh, PA 15222



IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC CORPORATION,	)	
a corporation	)	
Plaintiff,	)	Civil Action
	)	No. 88 1098
v.	)	
CYNTHIA ANN HOLLIDAY,	)	
an individual,	)	
Defendant.	)	

AFFIDAVIT

"I, DENESE WOJCIK, the Health Care Administrator for the FMC Salaried Health Care Plan, do hereby depose and say that the foregoing facts are true and accurate to the best of my knowledge.

/s/ Denese M. Wojcik  
Denese Wojcik

SWORN TO AND SUBSCRIBED  
BEFORE ME THIS 30th  
DAY OF November, 1988

/s/ Laura W. Olsen  
Notary Public

My Commission Expires:  
Laura W. Olsen  
Notary Public, Cook County, Illinois  
My Commission Expires March 4, 1989

IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC Corporation,	)	
a corporation	)	
Plaintiff,	)	Civil Action
	)	No. 88-1098
v.	)	
Cynthia Ann Holliday,	)	
an individual,	)	
Defendant.	)	

ORDER OF COURT

AND NOW, this \_\_\_ day of \_\_\_, 1988, upon consideration of the Motion for Summary Judgment of FMC Corporation, it is hereby Ordered, Adjudged, and Decreed that FMC Corporation is entitled to judgment as a matter of law and that defendant, Cynthia Holliday, and her counsel, as a result, must cooperate with and otherwise facilitate FMC's exercise of its subrogation rights.

BY THE COURT:

\_\_\_\_\_J.

## CERTIFICATE OF SERVICE

I hereby certify that true and correct copies of the foregoing Motion for Plaintiff, FMC Corporation, For Summary Judgment and Memorandum In Support Thereof were served on Counsel of Defendant by First Class, Prepaid Mail, this 2nd day of December, 1988:

Thomas G. Johnson, Esquire  
The Daugherty House  
824 Church Street  
Indiana, PA 15201

/s/ Charles Kelly  
Charles Kelly, Esquire  
Kirkpatrick & Lockhart  
1500 Oliver Building  
Pittsburgh, PA 15222  
(412) 355-6500

---

The following exhibits were attached to Plaintiff's Memorandum in Support of its Motion for Summary Judgment

---

**Exhibit A**

THOMAS G. JOHNSON  
ATTORNEY AT LAW  
SUITE 406 INDIANA THEATRE BUILDING  
INDIANA, PENNSYLVANIA 15701  
MARKET STREET  
BLAIRSVILLE  
MON & WED EVENINGS

TELEPHONE  
AREA CODE 412  
463-0226

January 19, 1988

PIMCO  
One PHICO Drive  
P. O. Box 85  
Mechanicsburg, Pennsylvania 17055-0085

RE: Your File : 686-87-1200  
Claimant : Cynthia Ann Holliday  
D/O/L : 1-16-87

ATTENTION: TAMMY M. LENKER

Dear Ms. Lenker:

Enclosed please find photocopies of the following medical invoices:

Children's Hospital	\$ 33,475.11
Rehabilitation Institute	\$144,450.00
Rehabilitation Institute (leg brace)	\$ 704.00
Total	\$178,626.11

Should you need further information, please feel free to contact this office.

Yours truly,  
Thomas G. Johnson

TGJ\*DB

Enclosures

**Exhibit B**

THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC Corporation,	)	
a corporation	)	
Plaintiff,	)	
v.	)	Civil Action
	)	No. 88-1098
Cynthia Ann Holliday,	)	
an individual,	)	
Defendant.	)	

AFFIDAVIT OF DENESE M. WOJCIK

COMMONWEALTH OF	)	
PENNSYLVANIA	)	SS:
COUNTY OF ALLEGHENY	)	

Before me, the undersigned notary public, this day personally appeared Denese M. Wojcik, to me known, who being duly sworn according to law, deposes and says:

1. I am the Administrator of Health Care Management at FMC Corporation ("FMC"). My office is located at 200 East Randolph Drive, Chicago, Illinois 60601. I am personally familiar with the facts contained in this affidavit. I make this affidavit in support of FMC's Motion for Summary Judgment.

2. My duties include the management of various health plans established and provided by FMC. Among those plans I supervise is the FMC Salaried Health Care



Plan ("Health Plan"). The Health Plan is filed with the U.S. Department of Labor under Plan No. PN540.

3. The Health Plan is self-insured.

4. The Health Plan is an employee welfare benefit plan within the meaning of 29 U.S.C. Sections 1002(1) and 1003(a)(1) of the Employee Retirement Income Security Act ("ERISA") since it was established and is maintained by FMC to provide beneficiaries medical, surgical and hospital care benefits in the event of sickness, accident or disability.

5. The Health Plan, in addition to providing benefits for FMC employees, also provides health care coverage for dependents of FMC employees. Those dependents include unmarried children less than 19 years old who reside in the household of an FMC employee.

6. Gerald S. Holliday ("Mr. Holliday"), the father and legal guardian of Cynthia Holliday ("Ms. Holliday"), is an employee of FMC and at all times relevant to this action subscribed to the Health Plan. Ms. Holliday is a beneficiary of the Health Plan.

7. Ms. Holliday in 1987, sustained serious injuries in an automobile accident and required medical treatment at the Children's Hospital of Pittsburgh and at the Rehabilitation Institute of Pittsburgh. FMC, on Ms. Holliday's behalf, has paid approximately \$67,768 in medical benefits for such treatment.

8. The Health Plan provides that FMC's self insured benefit program is automatically assigned the right of action a subscriber to the Health Plan brings against third

parties in any situation in which benefits are paid to employees or their dependents.

9. Upon learning that Mr. Holliday, on Ms. Holliday's behalf, had commenced a civil action in the Court of Common Pleas for Indiana County, Pennsylvania against the driver of the vehicle who was responsible for the accident in which Ms. Holliday was injured, FMC notified the Hollidays of its intention to exercise its subrogation rights with respect to the Indiana County action. Counsel for the Hollidays, Thomas G. Johnson, has objected to FMC's exercise of its subrogation rights, claiming that the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 precludes self insured medical providers, such as FMC, from exercising such rights.

/s/ Denese M. Wojcik  
Denese M. Wojcik

SUBSCRIBED AND SWORN  
TO BEFORE ME THIS 30th  
DAY OF November, 1988.

/s/ Laura W. Olsen  
Notary Public

My Commission Expires:  
Laura W. Olsen  
Notary Public, Cook County, Illinois  
My Commission Expires March 4, 1990

**Exhibit C**

IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC CORPORATION,  
A CORPORATION

Plaintiff

VS.

CYNTHIA ANN HOLLIDAY,  
AN INDIVIDUAL

Defendant

CIVIL ACTION  
NO. 88 1098

RESPONSE TO REQUEST FOR ADMISSIONS

1. Admitted: \_\_\_\_\_ Denied: XX

Defendant must deny this requested admission in that Exhibit A may or may not be a true and correct copy of the FMC Salaried Health Care Plan. Exhibit A purports to be a summary of such plan.

2. Admitted: XX Denied: \_\_\_\_\_  
3. Admitted: \_\_\_\_\_ Denied: XX

Defendant must deny this requested admission in that Exhibit A may or may not be a true and correct copy of the FMC Salaried Health Care Plan. Exhibit A purports to be a summary of such plan.

4. Admitted: \_\_\_\_\_ Denied: XX

Defendant must deny this requested admission in that Exhibit A may or may not be a true and correct copy of the FMC Salaried Health Care Plan. Exhibit A purports to be a summary of such plan.

5. Admitted: XX Denied: \_\_\_\_\_  
6. Admitted: XX Denied: \_\_\_\_\_

7. Admitted: XX Denied: \_\_\_\_\_  
8. Admitted: XX Denied: \_\_\_\_\_  
9. Admitted: XX Denied: \_\_\_\_\_  
10. Admitted: XX Denied: \_\_\_\_\_  
11. Admitted: XX Denied: \_\_\_\_\_  
12. Admitted: XX Denied: \_\_\_\_\_  
13. Admitted: \_\_\_\_\_ Denied: XX

This request must be denied in that although Ms. Holliday incurred, as of January 19, 1988, at least \$178,626.11 in medical bills, Defendant cannot be certain that as of that date substantially more medical expenses were incurred.

14. Admitted: XX Denied: \_\_\_\_\_  
15. Admitted: XX Denied: \_\_\_\_\_  
16. Admitted: \_\_\_\_\_ Denied: XX

Once again, although it would be admitted that medical benefits were paid through a health plan at FMC, it cannot be admitted that such benefits were paid through Exhibit A.

17. Admitted: XX Denied: \_\_\_\_\_  
18. Admitted: XX Denied: \_\_\_\_\_  
19. Admitted: XX Denied: \_\_\_\_\_

/s/ Thomas G. Johnson  
Thomas G. Johnson, Esquire  
824 Church Street  
Indiana, Pennsylvania 15701  
(412) 463-0226

Counsel for Defendant

## PROOF OF SERVICE

I hereby certify that a true and correct copy of the foregoing Response to Request for Admissions was served upon Kirkpatrick and Lockhart by first class mail, postage-prepaid, on November 29, 1988.

/s/ Thomas G. Johnson  
 Thomas G. Johnson, Esquire  
 Attorney for  
 Cynthia Ann Holliday,  
 an individual

IN THE UNITED STATES DISTRICT COURT  
 FOR THE WESTERN DISTRICT OF PENNSYLVANIA

FMC Corporation,	)	
a corporation	)	
Plaintiff,	)	
v.	)	Civil Action No.
Cynthia Ann Holliday,	)	
an individual,	)	
Defendant.	)	

PLAINTIFF, FMC CORPORATION'S, FIRST REQUEST  
 FOR ADMISSIONS ADDRESSED TO DEFENDANT,  
 CYNTHIA HOLLIDAY

Pursuant to Rule 36(a) of the Federal Rules of Civil Procedure Defendant, Cynthia Ann Holliday, is hereby required to answer the following Requests for Admissions, in writing, under oath, within ten (10) days hereof, to file such answers with the District Court for the Western District of Pennsylvania, and to serve a copy of such answers on Charles Kelly, Kirkpatrick & Lockhart, 1500 Oliver Building, Pittsburgh, PA 15222.

## Definitions and Instructions

1. "Ms. Holliday" refers to the defendant, Cynthia Ann Holliday.
2. "Mr. Holliday" refers to Gerald S. Holliday, the father of Ms. Holliday.
3. "FMC" refers to the plaintiff, FMC Corporation.
4. In answering these Requests for Admissions please furnish not only such information as is available to



the particular individual or individuals answering them, but also such information as is known to any guardian, representative, or agent of Ms. Holliday.

5. If the person or persons answering these Requests for Admissions are unable to answer any of them completely after exercising due diligence to secure the necessary information, such person or persons should answer each Request for Admission to the fullest extent possible.

6. These Requests for Admissions are continuing. In the event that any information comes to the attention of Ms. Holliday after she files her answers that is responsive to a Request for Admission, or which would change in any way a response, such additional information must be furnished to FMC's attorneys without further request.

#### Requests

1. Exhibit A attached hereto is a true and correct copy of the FMC Salaried Health Care Plan ("the Health Plan").

2. Mr. Holliday is an employee of FMC.

3. Mr. Holliday, during his employment, has subscribed to the Health Plan.

4. The Health Plan, in addition to providing benefits for FMC employees, also provides health care coverage for the dependents of FMC employees.

5. Ms. Holliday was injured in an automobile accident in White Township, Indiana County, Pennsylvania on January 16, 1987.

6. As a result of the accident, Ms. Holliday suffered severe injuries.

7. As a result of the accident, Ms. Holliday required medical treatment.

8. Ms. Holliday received medical treatment at Children's Hospital of Pittsburgh ("Children's Hospital"), 3705 Fifth Avenue at Desoto St., Pittsburgh, PA.

9. Ms. Holliday received medical treatment at The Rehabilitation Institute of Pittsburgh ("Rehabilitation Institute"), 6301 Northumberland Street, Pittsburgh, PA.

10. Ms. Holliday's attorney in this matter is Thomas G. Johnson ("Johnson").

11. Attached Exhibit B is a true and correct copy of a letter from Johnson to the Pennsylvania Insurance Management Company ("PIMCO").

12. Exhibit B was produced pursuant to a document request served by FMC on Ms. Holliday.

13. Ms. Holliday, by January 19, 1988, had incurred medical expenses of \$178,626.11.

14. Ms. Holliday, at the time of the 1987 accident, was a dependent of Mr. Holliday.

15. Ms. Holliday, at the time of receiving medical treatment from Children's Hospital and the Rehabilitation Institute, was a dependent of Mr. Holliday.

16. The Health Plan has provided benefits in connection with the medical expenses incurred by Ms. Holliday.

17. Attached Exhibit C is a true and correct copy of an FMC Third Party Reimbursement form completed, in part, by Johnson.

18. The signature appearing in Exhibit C above the language "Signature of Employee" is that of Mr. Holliday.

19. The signature appearing in Exhibit C was made on February 20, 1987.

Dated: November 15, 1988

\_\_\_\_\_

#### CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing First Request for Admissions Addressed to Defendant, Cynthia Holliday was served on Counsel of Defendant, by Purolator Courier Mail, this 15th day of November, 1988:

Thomas G. Johnson, Esquire  
The Daugherty House  
824 Church Street  
Indiana, PA 15201

/s/ Charles Kelly  
Charles Kelly, Esquire

\_\_\_\_\_

As Exhibit A to Plaintiff's First Request for Admissions Addressed to Defendant, Plaintiff attached a copy of the FMC Salaried Health Care Plan. This copy has been printed at pages 12 to 79, *infra*.

---

THOMAS G. JOHNSON  
ATTORNEY AT LAW  
SUITE 406 INDIANA THEATRE BUILDING  
INDIANA, PENNSYLVANIA 15701

MARKET STREET  
BLAIRSVILLE  
MON & WED EVENINGS

TELEPHONE  
AREA CODE 412  
463-0226

January 19, 1988

PIMCO  
One PHICO Drive  
P. O. Box 85  
Mechanicsburg, Pennsylvania 17055-0085

RE: Your File : 686-87-1200  
Claimant : Cynthia Ann Holliday  
D/O/L : 1-16-87

ATTENTION: TAMMY M. LENKER

Dear Ms. Lenker:

Enclosed please find photocopies of the following medical invoices:

Children's Hospital	\$ 33,475.11
Rehabilitation Institute	\$144,450.00
Rehabilitation Institute	\$ 704.00
(leg brace)	
Total	\$178,626.11

Should you need further information, please feel free to contact this office.

Yours truly,

Thomas G. Johnson

TGJ\*DB  
Enclosures

EXHIBIT B TO PLAINTIFF'S FIRST  
REQUEST FOR ADMISSIONS

---



## GENERAL LIABILITY

FMC Corporation  
200 East Randolph Drive  
Chicago, Illinois 60601

## Third Party Reimbursement

Name: Gerald S. Holliday

Location: White Twp., Indiana County, PA.

Social Security No.: \_\_\_\_\_

1. Benefit Plan Number: \_\_\_\_ Branch: \_\_\_\_ Location \_\_\_\_
2. Date of accident Jan. 18th 1987  
Time of accident 2315 Hours  
Were police or emergency units called? Yes  
If called, please identify. Ambulance, PA. State Police  
(Trp. George A. Kuzilla)
3. Location of accident (in detail) See attached police report
4. Description of Accident See attached police report
5. Name and address of the person or persons who caused the loss or are responsible.  
Robert Scott Lyons  
941 McHenry Road, Indiana, PA. 15701
6. Name, address, and telephone number of responsible parties' insurance company.  
Celina Insurance Group  
Bill Lewis, Adjuster  
Box 396 Martinsburg, PA.
7. The name, address, and telephone number of your attorneys.  
Thomas G. Johnson  
Suite 406 Ind. Theatre Bldg.  
Indiana, PA. 15701

**EXHIBIT C TO PLAINTIFF'S  
FIRST REQUEST FOR ADMISSIONS**

8. Name, address, and telephone number of responsible party's attorney (if available).  
Not available
  9. Will suit or claim be made against the responsible party? yes  
If not, please explain why. \_\_\_\_\_
  10. Other comments. \_\_\_\_\_
- Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## FMC CORPORATION

## Third Party Reimbursement Notification

The Plan of Benefits provided by FMC Corporation includes a third party reimbursement provision.

As a condition of eligibility to receive benefits under the Plan, each covered person (including the employee on his own behalf; and on behalf of his dependents) agrees that the Company shall be reimbursed to his rights to recovery of damages, to the extent benefits are provided under the Plan, for illness or injury of himself or of any covered person which is caused by the alleged negligence of any third person, and assigns to the Company such cause of action.

In the event that any Covered Person must accept personal responsibility for or contract to pay his own special damages in order to recover them from such third person, he hereby accepts such personal responsibility and makes such contract to the extent necessary to make assignment to the Company effective and valid.

I,     , hereby agree, for myself, my heirs, executors, administrators and assigns, to reimburse the Equitable Life Assurance Society of the United States for any amounts which I may receive for myself or on behalf of my eligible covered dependents under the Plan for bodily injuries or sickness for which claim has been submitted. If I bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled I must reimburse the Plan for the benefits provided. I am obligated to avoid doing anything which would prejudice the Plan's rights of reimbursement, and I understand that I may be required to

sign and deliver documents to evidence or secure those rights.

Such reimbursement shall be limited to benefits paid under the Plan but in no event in an amount in excess of the proceeds of any such recovery after the deduction of reasonable and necessary expenditures, including attorney's fees, incurred in effecting such recovery.

Gerald S. Holliday  
Employee Name  
(Print)

X /s/ Gerald S. Holliday  
Signature of Employee

Social Security No.  
X 186 36 5603

\_\_\_\_\_  
Signature of Patient  
(if not employee)

\_\_\_\_\_  
Signature of Witness

X 2/20/87  
Date

\_\_\_\_\_

**EXHIBIT D**IN THE COURT OF COMMON PLEAS OF  
INDIANA COUNTY, PENNSYLVANIA

## CIVIL DIVISION

CYNTHIA ANN	)	Date Filed _____
HOLLIDAY, a	)	
minor, by	)	No. 535 C.D. 1987
GERALD S.	)	
HOLLIDAY,	)	
her guardian,	)	
	)	
Plaintiffs	)	
-vs-	)	Type of Pleading:
	)	PETITION FOR INTERPLEADER
ROBERT	)	
SCOTT LYONS,	)	
	)	
Defendant	)	

## Counsel for This Party:

GERALD J. YANITY, Esquire  
PA I. D. No. 22067

STEWART, BELDEN and  
BELDEN

Attorneys at Law  
Belden Building  
117 North Main Street  
Greensburg, PA 15601  
(412) 834-0300

Attorneys for Defendant

IN THE COURT OF COMMON PLEAS OF  
WESTMORELAND COUNTY, PENNSYLVANIA

## CIVIL DIVISION

CYNTHIA ANN HOLLIDAY, a	)	
minor, by	)	
GERALD S. HOLLIDAY, her	)	
guardian,	)	
	)	
Plaintiffs	)	
-vs-	)	No. 535 C.D.
	)	1987
ROBERT SCOTT LYONS,	)	
	)	
Defendant	)	

## PETITION FOR INTERPLEADER

TO THE HONORABLE, THE JUDGES OF SAID COURT:

The Petition of ROBERT SCOTT LYONS, by and through his counsel, Stewart, Belden and Belden, respectfully represents:

1. ROBERT SCOTT LYONS is the defendant in this action.

2. The action was commenced by a Complaint filed at the above number and term on April 21, 1987, alleging, inter alia, that on January 16, 1987, your petitioner negligently operated a motor vehicle, causing it to strike another motor vehicle, wherein the minor plaintiff, Cynthia Ann Holliday, was injured. The plaintiffs allege that her damages are in excess of One Hundred Thousand (\$100,000.00) Dollars.

3. Your petitioner has been advised that Clay Harkleroad, a passenger in the other vehicle involved in the



accident, has made a claim or demand against him for injuries arising out of the same accident, which claim may be inconsistent with the cause of action asserted by the plaintiffs.

4. Your petitioner expects that Douglas B. Bush, a passenger in his automobile at the time of the accident, and Mark Edward Howell, the operator of the other motor vehicle involved in the accident, as well as Mary Jane Fulmer, a passenger in said other motor vehicle (all of who were injured in the accident of January 16, 1987), will also make demands or claims against him for injuries or damages arising out of the accident which may be inconsistent with the cause of action asserted by the plaintiffs.

5. The assertion of the claim by Clay Harkleroad, as well as the expected claims by Douglas B. Bush, Mary Jane Fulmer and Mark Edward Howell, may expose your petitioner to multiple liability in that his insurance coverage has a single limit of One Hundred Thousand (\$100,000.00) Dollars, and all of the claims or demands against him, or expected to be made against him, will exceed that amount.

6. This Petition is filed in good faith and not in collusion with any party to this action or with the plaintiffs.

7. Your petitioner claims no interest in the amount in controversy, and is willing to pay his insurance policy limits into Court, or to such person as the Court may direct.

8. Your petitioner has not admitted the claim of, or subjected himself to independent liability to, the plaintiffs, or any claimant, in respect to the subject matter of the action.

**WHEREFORE**, your petitioner respectfully asks that the Court order all of the above claimants or expected claimants to interplead, and to stay all proceedings meanwhile, pursuant to the provisions of PA R.C.P. 2303.

Respectfully submitted,

STEWART, BELDEN and BELDEN

By /s/ Gerald J. Yanity  
Attorneys for Defendant

Belden Building  
117 North Main Street  
Greensburg, PA 15601  
(412) 834-0300

## A F F I D A V I T

COMMONWEALTH )  
 OF PENNSYLVANIA )  
 ) SS:  
 COUNTY OF )  
 WESTMORELAND )

Before me, the undersigned authority in and for said County and Commonwealth, personally appeared ROBERT SCOTT LYONS, within petitioner, who, being duly sworn according to law, deposes and says that the facts set forth in the foregoing Petition for Interpleader are true and correct to the best of his knowledge, information and belief.

/s/ Robert Scott Lyons  
 Robert Scott Lyons

SWORN to and subscribed  
 before me this 11th  
 day of August,  
 1987.

/s/ Henrietta C. Rutledge  
 Notary Public

My Commission Expires:  
 HENRIETTA C. RUTLEDGE  
 NOTARY PUBLIC  
 WESTMORELAND CO. PENNA  
 COMMISSION EXPIRES 3 July 1988

IN THE COURT OF COMMON PLEAS OF  
INDIANA COUNTY, PENNSYLVANIA

## CIVIL DIVISION

CYNTHIA ANN HOLLIDAY,	)	
a minor, by	)	
GERALD S. HOLLIDAY, her	)	
guardian,	)	
	)	
Plaintiffs	)	No. 535 C.D.
-vs-	)	1987
ROBERT SCOTT LYONS,	)	
	)	
Defendant	)	
	)	

## ORDER OF COURT

AND NOW, This 3rd day of SEPTEMBER, 1987, the Petition of **ROBERT SCOTT LYONS** is granted and **DOUGLAS B. BUSH, MARY JANE FULMER, CLAY A. HARKLEROAD** and **MARK EDWARD HOWELL** are added to the record as party plaintiffs and are enjoined from commencing or further prosecuting any action in any court against **ROBERT SCOTT LYONS** to enforce in whole or in part any claim or claims against him set forth in said Petition, except as a party or parties to the above entitled action.

**NOW, THEREFORE**, we command you, the Sheriff of the County of Indiana, Commonwealth of Pennsylvania, to direct the claimants, **DOUGLAS B. BUSH**, 51 South 14th Street, Indiana, Pennsylvania, 15701; **MARY JANE FULMER**, R. D. #1, Creekside, Pennsylvania, 15732;

**CLAY A. HARKLEROAD**, 109 Royal Garden Court, Indiana, Pennsylvania, 15701; and **MARK EDWARD HOWELL**, 492 East Pike, Indiana, Pennsylvania, 15701, to file in the above entitled action in the office of the Prothonotary of the Court of Common Pleas of Indiana County, Pennsylvania, Civil Division, a complaint within twenty (20) days after being served with copies of the Petition for Interpleader and this Order and all pleadings heretofore filed in the above entitled action if said service was made within your County, or within thirty (30) days of said service if said service was made within any other county of this Commonwealth.

BY THE COURT:

/s/ Robert Earley

Judge

ATTEST:

\_\_\_\_\_

\_\_\_\_\_

As Exhibit E to Plaintiff's Memorandum in Support of Its Motion for Summary Judgment, Plaintiff attached a copy of 75 Pa. Cons. Stat. Ann. §§1703-1704, 1711-1724, 1731 (Purdons 1984).

\_\_\_\_\_



As Exhibit F to Plaintiff's Memorandum in Support of Its Motion for Summary Judgment, Plaintiff attached a copy of 75 Pa. Cons. Stat. Ann. §§1701-1704 (Purdons 1984).

---

As Exhibit G to Plaintiff's Memorandum in Support of Its Motion for Summary Judgment, Plaintiff attached a copy of Sections 111 and 203 of Pennsylvania's No-Fault Act, 40 P.S. §§111, 203.

---

Plaintiff

CYNTHIA ANN HOLLIDAY,  
AN INDIVIDUAL

Defendant

\*  
\*  
\*  
\*  
\*  
\* CIVIL ACTION  
\* NO.  
\* 88 1098  
\*  
\*  
\*

Defendant, Cynthia Ann Holliday, by her Attorney, moves this Court, pursuant to Rule 56 of the Federal Rules of Civil Procedure for Summary Judgment in favor of the Defendant and against the Plaintiff, FMC Corporation, a corporation. In support of this Motion, Defendant relies on the pleadings filed in this matter and the anticipated response from Plaintiff to Request for Admissions, and avers as follows:

1. On January 16, 1987, Cynthia Ann Holliday, a minor and natural child of Gerald Holliday, was seriously injured in an automobile accident in Indiana County, Pennsylvania.

2. On October 1, 1984, the Pennsylvania Motor Vehicle Financial Responsibility Law, 75 Pa. C.S.A. 1701, *et seq.* went into effect which provided under Section 1720:

In action arising out the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a Claimant's

tort recovery with respect to. . . , or benefits in lieu thereof paid or payable under Section 1719 (relating to coordination of benefits).

3. At the time of the aforesaid accident, Gerald Holliday was employed by FMC Corporation and enrolled in the FMC Health Plan.

4. FMC Corporation and the FMC Health Plan, under its own contractual terms, had the obligation to provide health benefits to Cynthia Ann Holliday for medical services occasioned by her injuries.

5. FMC Corporation and the FMC Health Plan, accepted the jurisdiction of, and derived the benefits from, the Pennsylvania Motor Vehicle Financial Responsibility Law, 75 Pa. C.S.A. Section 1711 (relating to required benefits) by requiring State Farm Mutual Insurance Company to pay the first \$10,000.00 of medical expenses incurred by Cynthia Ann Holliday.

6. FMC Corporation and the FMC Health Plan, accepted the jurisdiction of and derived the benefits from the Pennsylvania Motor Vehicle Financial Responsibility Law 75 Pa. C.S.A. Section 1713 (relating to source of benefits) by requiring State Farm Mutual Insurance Company to pay the first \$10,000.00 of medical expenses incurred by Cynthia Ann Holliday.

7. FMC Corporation and the FMC Health Plan, accepted the jurisdiction of and derived the benefits from the Catastrophic Loss Trust Fund, 75 Pa. C.S.A. Section 1761 *et seq.* by avoiding payment of all medical expenses of Cynthia Ann Holliday which were in excess of \$100,000.00 or by requesting repayment from the Fund

for any bills paid by them which were in excess of \$100,000.00.

8. As a matter of law, by availing themselves of the jurisdiction and benefits of the aforementioned provisions of Pennsylvania Law, FMC Corporation and the FMC Health Plan have waived their right to seek Federal Preemption of other provisions under such law that they wish to disregard, namely the prohibition against subrogation found in 75 Pa. C.S.A. Section 1720.

9. There are no genuine issues of material fact and Defendant is entitled to judgment as a matter of law.

10. Defendant Cynthia Ann Holliday reserves the right to file a Supplemental Motion for Summary Judgment and Brief in Support thereof upon receipt of Plaintiff's Response to Requested Admissions and Response to Request for Documents.

WHEREFORE, Defendant requests that this Honorable Court enter Summary Judgment in favor of the Defendant declaring that FMC Corporation and the FMC Health Plan is not entitled to subrogate against the third-party tort claim of Cynthia Ann Holliday.

Respectfully submitted,

/s/ Thomas G. Johnson  
Thomas G. Johnson, Esquire  
Attorney for Defendant



*PROOF OF SERVICE*

I hereby certify that a true and correct copy of the foregoing Motion for Summary Judgment was served upon Charles Kelly, Esquire of Kirkpatrick and Lockhart, 1500 Oliver Building, Pittsburgh, Pennsylvania 15222-5379, by first class mail, postage prepaid, on December 2, 1988.

/s/ Thomas G. Johnson  
Thomas G. Johnson, Esquire  
Attorney for Cynthia Ann  
Holliday

---

The following exhibits were attached to Defendant's Memorandum in Support of Its Motion for Summary Judgment.

---

As Exhibit A to Defendant's Memorandum in Support of Its Motion for Summary Judgment, Defendant attached a copy of 75 Pa. Cons. Stat. Ann. §§1703-1704, 1711-1724 (Purdons 1984).

## Exhibit "B"

## PAYMENT TRANSMITTAL

✓ -	STATE FARM MUTUAL AUTO-MOBILE INSURANCE COMPANY	-	STATE FARM LLO
	NY	-	STATE FARM COUNTY MUTUAL INSURANCE COMPANY OF TEXAS
(SEAL) -	STATE FARM FIRE AND CASUALTY COMPANY		
-	STATE FARM GENERAL INSURANCE COMPANY		

DATE	INSURED	DATE OF ACCIDENT OR OCCURRENCE	CLAIM NUMBER
2/6/87	Holliday, Gerald	1/16/87	38-15222-712

Gerald Holliday  
1569 Church St.  
Indiana, PA 15701

From:  
STATE FARM INSURANCE CLAIM OFFICE  
389 NEW CASTLE ROAD  
P. O. BOX 2189  
BUTLER, PA 16003

For Cynthia Holliday

By: /s/ Erny Wilson

Fold \_

Payment for items listed below has been sent to the provider.

✓ Here is our payment for the items listed below.

Please keep this letter as your record of payments made.

Item	Amount Paid At This Time	Amount Paid Previously	Total Paid To Date
Citizens Ambulance	\$220.00	\$_____	\$_____
Indiana Hospital	\$894.90	\$_____	\$_____
TOTAL	\$1114.90	\$_____	\$1114.90

Payments made are subject to the Company's right of subrogation or reimbursement.

For all payments require your completion of the attached Proof of Claim on (DATE)

- Complete this form and return in the enclosed postage paid return envelope.

Remarks:

## PAYMENT TRANSMITTAL

✓ - STATE FARM MUTUAL AUTO-  
MOBILE INSURANCE COMPA-  
NY

(SEAL) - STATE FARM FIRE AND CASU-  
ALTY COMPANY

- STATE FARM GENERAL IN-  
SURANCE COMPANY

- STATE FARM LLO

- STATE FARM COUNTY MUTUAL IN-  
SURANCE COMPANY OF TEXAS

DATE	INSURED	DATE OF ACCIDENT OR OCCURRENCE	CLAIM NUMBER
3/3/87	Holliday, Gerald & Karen	1/16/87	38-1522-712

Gerald Holliday  
1569 Church St.  
Indiana, PA 15701

## For Cynthia Holliday

By: /s/ Erny Wilson

Fold



Payment for items listed below has been sent to the provider.

✓ Here is our payment for the items listed below.

Please keep this letter as your record of payments made.

Item	Amount Paid At This Time	Amount Paid Previously	Total Paid To Date
Illegible	\$246.75	\$	\$
S.R.T. Radiologists	\$1,295.00	\$	\$
Illegible	\$680.00	\$	\$
Illegible	\$113.00	\$	\$
TOTAL	\$2,334.75	\$1,114.90	\$3,449.65

142

- Payments made are subject to the Company's right of subrogation or reimbursement.
- Further payments require your completion of the attached Proof of Claim on (DATE)
- Complete this form and return in the enclosed postage paid return envelope.

Remarks: Please Pay Illegible and SRT Radiologists

#### PAYMENT TRANSMITTAL

✓ STATE FARM MUTUAL AUTO-  
MOBILE INSURANCE COMPA-  
NY

(SEAL) - STATE FARM FIRE AND CASU-  
ALTY COMPANY

- STATE FARM GENERAL IN-  
SURANCE COMPANY

- STATE FARM LLO

- STATE FARM COUNTY MUTUAL IN-  
SURANCE COMPANY OF TEXAS

DATE	INSURED	DATE OF ACCIDENT OR OCCURRENCE	CLAIM NUMBER
2/6/87	Holliday, Gerald & Karen	1/16/87	38-1522-712

143

Gerald Holliday  
1569 Church St.  
Indiana, PA 15701

From:  
STATE FARM INSURANCE CLAIM OFFICE  
389 NEW CASTLE ROAD  
P. O. BOX 2189  
BUTLER, PA 16003

For Cynthia Holliday

By: /s/ Erny Wilson

Fold

- Payment for items listed below has been sent to the provider.

✓ Here is our payment for the items listed below.

Please keep this letter as your record of payments made.

Item	Amount Paid At This Time	Amount Paid Previously	Total Paid To Date
Childrens Hospital	\$6,550.35	\$3,449.65	\$10,100.00
99 State Farm's benefit applies		\$	\$
TOTAL	\$	\$	\$

144

- Payments made are subject to the Company's right of subrogation or reimbursement.

- Further payments require your completion of the attached Proof of Claim on (DATE)

- Complete this form and return in the enclosed postage paid return envelope.

Remarks: illegible

### EXPLANATION OF BENEFITS PROVIDED BY YOUR GROUP MEMBERSHIP

LOCATION: HOMER CITY NO: 70135 0006 G  
FMC CORPORATION NAME: HOLLIDAY, GERALD  
ID NUMBER: 186365603 DEPENDENTS NAME: CYNTHIA  
RELATIONSHIP: CHILD CL BR: 5 DATE: MAY 1, 1987  
Illegible: 518 CLAIM NUMBER: 870501 1524129 FOR INFORMATION CALL: 2907

145

Type Of Expense Or Name Of Provider	Period From Through	Charges	At 90%	Benefits	See Below
INTENSIVE CARE	01/17-01/21/87	3980.00	3980.00		
SEMI-PRIVATE ROOM	01/22-02/02/87	6540.00	6540.00		
TOTAL CHARGES		10520.00	10520.00		

BENEFIT  
DUPLICATE COVERAGE ADJUSTMENT

9468.00  
-9468.00

NET BENEFIT

.00

STATE FARM'S BENEFIT APPLIED.

- ANOTHER EXPLANATION OF BENEFITS WILL FOLLOW. THANK YOU.

037-3-007327

5-5-87

Ardyce:

Please review the attached, the prior payment by State Farm was not to Children's hospital, it was to several other providers as noted on the payment statement. These other bills were submitted directly to and paid by State Farm in the amount of \$3,449.65, thus shouldn't you pay more directly to Children's hospital and give amount payee the necessary credit on the noted billings for the \$3,449.65.

/s/ Sharon

LOCATION'S COPY

THE EQUITABLE LIFE ASSURANCE SOCIETY  
AS CLAIMS ADMINISTRATOR



(SEAL)

Date: \_\_\_\_\_

Employer: FMC Corporation  
 Plan No.: 755307  
 Branch No.: 2A  
 Social Security No.: Illegible  
 Employee: Gerald Holliday  
 Patient: Cynthia  
 Date of Accident: Illegible

Provider of Service	Date of Service	Total Charge	Benefits Paid
Pitts. Radiology Assoc.	2/4/87	\$ 68.00	\$ 61.20
Childrens Hosp. - Pitts.	2/16/87	43.00	43.00
Univ. Surg. Assocs.	1/17/87	1,051.00	1,051.00
Rehab. Inst. - Pitts.	2/2-2/28/87	18,225.00	18,225.00
Childrens Hosp. - Pitts.	1/17-2/2/87	10,620.00	.00
Childrens Hosp. - Pitts.	1/17-2/2/87	18,364.00	17,390.89
Univ. Neuros. Assoc.	1/17-2/1/87	520.00	520.00
SRT Radiologists	2/18/87	160.00	160.00
Radiologic Illegible	1/17/87	46.00	46.00
Childrens Hosp. - Pitts.	3/16/87	43.00	43.00
Childrens Hosp. Pitts.	4/27/87	125.00	125.00
Illegible	1/18/87	330.00	330.00
Childrens Hosp. - Pitts.	2/1-2/2/87	4591.02	4591.02
Childrens Hosp. - Pitts.	2/18/87	892.00	892.00
Childrens Hosp. - Pitts.	1/87-2/87	10520.00	3350.00
Rehab. Inst. - Pitts.	3/5/87	731	731
Indiana Hosp.	1/17/87	Illegible	Illegible
Rehab Inst. - Pitts.	3/1-4/30/87	9450.00	5737.50
Childrens Hosp. - Pitts.	9/21/87	47.00	47.00
Totals		76,765.01	53,427.61

As Exhibit C to Defendant's Memorandum in Support of Its Motion for Summary Judgment, Defendant attached copies of 75 Pa. Cons. Stat. Ann. §§1757, 1761-1765 (Purdons 1984).

---

Supreme Court, U.S.

FILED

APR 20 1990

JOSEPH F. SPANIOL, JR.,  
CLERK

No. 89-1048

In The  
Supreme Court of the United States  
October Term, 1989

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FMC CORPORATION

*Petitioner,*

vs.

CYNTHIA ANN HOLLIDAY

*Respondent.*

---

On Writ Of Certiorari To The United States  
Court Of Appeals For The Third Circuit

---

BRIEF FOR THE PETITIONER

---

H. WOODRUFF TURNER, ESQ.\*

CHARLES KELLY, ESQ.

PATRICK J. McELHINNY, ESQ.

Of Counsel:

W. RONALD COOPER, ESQ.

FMC Corporation

200 East Randolph Drive

Chicago, Illinois 60601

KIRKPATRICK & LOCKHART

1500 Oliver Building

Pittsburgh, Pennsylvania 15222

(412) 355-6500

*Counsel for Petitioner*

\* Counsel of Record

---

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964  
OR CALL COLLECT (412) 342-2831

**BEST AVAILABLE COPY**



**QUESTION PRESENTED**

Whether ERISA's express preemption provisions, as interpreted in *Metropolitan Life v. Massachusetts*, prohibit states from applying state insurance regulations directly to self-funded employee welfare benefit plans?

## PARTIES TO THE PROCEEDINGS

Petitioner, FMC Corporation, is a Delaware corporation with its principal place of business in Illinois. FMC's subsidiaries include: FMC do Brasil S.A., FMC Mid-Atlantic Investments Limited, Mid-Atlantic Acceptance Company Limited, FMC Gold Company, FMC Paradise Peak Corporation, FMC Jerritt Canyon Corporation, FMC International, A.G., FMC Wyoming Corporation, Foret, S.A., Lithium Corporation of America. Respondent, Cynthia Ann Holliday, is an individual and citizen of Pennsylvania.

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## OPINIONS BELOW

The opinion of the United States District Court for the Western District of Pennsylvania (C1) is not officially reported. The opinion of the United States Court of Appeals for the Third Circuit is reported at 885 F.2d 79 (3d Cir. 1989). (A1).\*

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## JURISDICTION

The court of appeals rendered its opinion and entered judgment in favor of Defendant/Respondent, Cynthia Ann Holliday, on September 11, 1989. (A1). FMC Corporation ("FMC") filed a Motion for Rehearing *En Banc* on September 21, 1989, which was denied by the court of appeals on October 5, 1989. (B1).

This Court has jurisdiction over this appeal pursuant to 28 U.S.C. § 1254(1) and its order dated February 20, 1990, granting FMC's Petition for a Writ of Certiorari.

---

## STATUTES INVOLVED

Section 514(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), provides:

---

\* The following opinions or orders have been reprinted in FMC's Petition for Writ of Certiorari: Opinion of the court of appeals - A1. Order of the court of appeals denying rehearing - B1. Opinion of the district court - C1. Unreported opinion in *FMC Corp. v. Good Samaritan Hosp. of the Santa Clara Valley*, (No. C-88-3092-FMS) (N.D. Cal. 1988) - D1.

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

29 U.S.C. § 1144(a).

Section 514(b)(2) of ERISA provides:

(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2).

At all times relevant to this action, Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 (the "Financial Responsibility Law") provided:

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's

tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under section 1719 (relating to coordination of benefits).

75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1984).

Section 1720 was amended on February 7, 1990 to provide, effective July 1, 1990:

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits paid or payable by a program, group contract or other arrangement whether primary or excess under section 1719 (relating to coordination of benefits).

75 Pa. Cons. Stat. Ann. § 1720 as amended February 7, 1990, effective July 1, 1990.

Section 1719 of the Financial Responsibility Law provides:

(a) *General rule.* - Except for workers' compensation, a policy of insurance issued or delivered pursuant to this subchapter shall be primary. Any program, group contract or other arrangement for payment of benefits such as described in Section 1711 (relating to required benefits) 1712(1) and (2) (relating to availability of benefits) or 1715 (relating to availability of adequate limits) shall be construed to contain a provision that all benefits provided therein shall be in



excess of and not in duplication of any valid and collectible first party benefits provided in section 1711, 1712 or 1715 or workers' compensation.

(b) *Definition.* - As used in this section the term "program, group contract or other arrangement" includes, but is not limited to, benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa.C.S.Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

75 Pa. Cons. Stat. Ann. § 1719 (Purdon 1984).

#### STATEMENT OF THE CASE

FMC operates a self-funded employee benefit plan, the FMC Salaried Health Care Plan (the "Health Plan"), that pays the medical expenses incurred by FMC employees and their covered dependents.<sup>1</sup> FMC provides all funds used by the Health Plan to pay such medical benefits; FMC does not purchase insurance to provide these benefits.<sup>2</sup> (C1).

<sup>1</sup> The Health Plan is an employee welfare benefit plan as defined in ERISA, see 29 U.S.C. §§ 1002(1) and 1003(a)(1), because it was established and is maintained by FMC to provide beneficiaries with medical, surgical and hospital care benefits in the event of sickness, accident or disability. (J.A. 106). A copy of the Health Plan is included in the Joint Appendix. (J.A. 12-79).

<sup>2</sup> Self-funded plans cover a vast number of American workers. More than 9-1/2 million Americans are covered by  
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The Health Plan seeks to contain costs by, among other ways, providing for the exercise of subrogation rights and for coordination of benefits. The Health Plan provides to FMC the following subrogation rights:

The FMC self-insured benefit program is automatically assigned the right of action against third parties in any situation in which benefits are paid to employees or their dependents. If you bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled you must reimburse the Plan for the benefits provided.

(C2).

In addition, the Health Plan provides for coordination of benefits as follows:

If you or a covered member of your family are eligible to receive benefits under another group medical plan, Health Maintenance Organization (HMO), government plan, or by "no-fault" automobile insurance which provides medical coverage, you may be eligible for benefits from those Plans and your FMC plan. In the case of coverage by "no-fault" automobile insurance, FMC

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health plans that are self-funded. "Employee Benefits in Medium and Large Firms, 1988", U.S. Department of Labor, Bureau of Labor Statistics, Bulletin 2336 (August 1988). Moreover, a 1986 study by the Health Care Financing Administration (a division of the U.S. Department of Health and Human Services) revealed that four out of every five companies and unions with 5,000 or more plan participants operated self-funded health care plans. P. McDonnell, A. Guttentberg, L. Greenberg, R.H. Arnett III, "Self-Insured Health Plans," *HCEA Review*, Vol. 8 No. 2 (1986).

will pay covered expenses not paid for by no-fault insurance.

\* \* \*

#### No-Fault

In some states with no-fault motor vehicle coverage, the carrier is the primary insurer in these jurisdictions. All medical expenses related to an accident must be submitted to the carrier and not the FMC Health Care Plan. Eligible expenses not paid for by no-fault insurance *will* be paid by the FMC Plan.

*FMC Corp. v. Holliday*, 885 F.2d 79, 80-81 (3d Cir. 1989), cert. granted, 110 S.Ct. 1109 (1990).

Gerald Holliday, an FMC employee, subscribed to FMC's Health Plan, and his daughter, Cynthia Ann Holliday ("Holliday"), was a covered dependent. (C1). Ms. Holliday was injured in a 1987 automobile accident. (C1). Pursuant to the Health Plan's coordination of benefits provisions, the first \$10,000 of Ms. Holliday's medical expenses were paid through her father's State Farm automobile insurance policy, the so-called "no-fault" insurer referred to in the Health Plan's coordination of benefits provisions. *FMC*, 885 F.2d at 81. The Health Plan then paid a substantial portion of the remaining \$178,000 in expenses. (C1).

Thereafter, FMC learned that the Hollidays had filed a tort action in Pennsylvania state court (the "Pennsylvania Action") against the negligent driver.<sup>3</sup>

<sup>3</sup> On May 2, 1989, the court in the Pennsylvania Action approved a settlement agreement whereby \$49,875.50 plus

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Invoking the terms of the Health Plan, FMC notified the Hollidays that it intended to exercise its subrogation rights with respect to any recovery. (C2). The Hollidays rejected FMC's claim, contending that Section 1720 of the Financial Responsibility Law prohibits such subrogation.<sup>4</sup> (C3). Thereupon, FMC sought a declaratory judgment from the district court.<sup>5</sup>

Both FMC and Ms. Holliday moved for summary judgment. The district court (Bloch, J.) found that no material facts were in dispute, denied FMC's motion, granted Ms. Holliday's motion and entered judgment in her favor. *FMC Corp. v. Holliday*, No. 88-1098 (W.D. Pa. 1989) (C1).

The court of appeals affirmed the district court's judgment, holding: (1) that Section 1720 of the Financial Responsibility Law applies to self-funded plans and precludes FMC from exercising its subrogation rights under the Health Plan, *FMC*, 885 F.2d at 83; (2) that Section 1720 of the Financial Responsibility Law does not conflict with a "core type of ERISA matter" that Congress sought

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accrued interest was placed in an escrow account in the name of Ms. Holliday pending the outcome of this action. *FMC*, 885 F.2d at 80.

<sup>4</sup> Before reaching the preemption question presented to this Court, both the district court and the court of appeals held that Section 1720 applies to self-funded plans such as the Health Plan. (C3-C7); *FMC*, 885 F.2d at 81-83.

<sup>5</sup> The district court's jurisdiction was invoked under 28 U.S.C. § 1332. FMC is incorporated in Delaware and has its principal place of business in Illinois; Holliday is a citizen of Pennsylvania.

to protect by the preemption provisions; and (3) that Section 514 of ERISA does not, therefore, preempt Section 1720 as applied to FMC's self-funded Health Plan. *Id.* at 83-90.

FMC filed a Petition for Writ of Certiorari citing the public importance of the ERISA preemption issue and the conflicting rulings of the several courts of appeals on this issue. The Petition was granted on February 20, 1990.

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### SUMMARY OF ARGUMENT

The Court of Appeals for the Third Circuit erred by holding that the Commonwealth of Pennsylvania, through a state insurance law, could prohibit FMC from including an enforceable subrogation provision in its self-funded employee benefit plan. The plain language of ERISA's preemption provisions allows states to regulate insurance products purchased by an employee benefit plan on the strength of the "insurance saving" clause, Section 514(b)(2)(A), but prohibits states from treating a benefit plan as if it were engaged in the business of insurance and directly controlling the terms of a self-funded benefit plan. As this Court held in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), proper interpretation of ERISA's so-called "deemer clause," Section 514(b)(2)(B), limits the scope of the insurance saving clause, thus entirely shielding self-funded plans from the effects of state insurance regulation. ERISA expressly preempts the application of Section 1720 of the Financial Responsibility Law to self-funded benefit plans, such as the Health Plan.

To reach its result, the court of appeals misread ERISA's legislative history and erroneously narrowed the scope of preemption as applied to self-funded plans to situations where state insurance regulation impinges on core ERISA concerns. As this Court recognized in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983), and *Metropolitan Life*, Congress specifically rejected limiting preemption to those situations where state laws conflicted with certain of the substantive mandates of ERISA, but instead mandated broad preemption. The court of appeals misconstrued the language of the deemer clause, drew unwarranted conclusions from ERISA's legislative history and defined the scope of the deemer clause in a manner directly contrary to congressional intent.

Finally, preemption of state insurance regulations as applied directly to benefit plans furthers the fundamental purposes of ERISA. Congress sought nationally uniform regulation of employee benefit plans to relieve plans from the costly and complex administrative burden of complying with a patchwork scheme of conflicting state regulations. The clarity of the rule that prohibits states from directly regulating benefit plans, as opposed to the insurance products the plans may purchase, reduces opportunities for controversy, thus furthering Congress' efforts to protect plans from costly and protracted litigation. This Court's holding in *Metropolitan Life* advances those congressional goals. FMC's interpretation of the deemer clause achieves those results. The court of appeals' action does not.

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## ARGUMENT

### Section 514 of ERISA Preempts Direct State Regulation of Self-Funded Employee Benefit Plans.

ERISA establishes a federal regulatory scheme for employee benefit plans and, as a general matter, expressly preempts state regulation of such plans. As an exception to that broad federal preemption, ERISA's insurance saving clause permits state regulation of the insurance industry. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), held that ERISA's deemer clause forbids direct state regulation of employee welfare benefit plans, although ERISA's insurance saving clause does permit indirect regulation of employee benefit plans that purchase state-regulated insurance products. *Id.* at 741, 747. Accordingly, the Court of Appeals for the Third Circuit erred in holding that an insurance regulation, *i.e.*, Section 1720 of Pennsylvania's Financial Responsibility Law, could be applied to FMC's self-funded Health Plan.

#### A. ERISA Requires Preemption of State Insurance Regulations As Applied Directly to Benefit Plans.

"The purpose of Congress is the ultimate touchstone" of every preemption question. *Pilot Life Ins. Co. v. Dedaux*, 481 U.S. 41, 45 (1987) (citations omitted). Preemption "is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose." *Metropolitan Life*, 471 U.S. at 738. Accordingly, any preemption inquiry must "begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose."

*Id.* at 740 (quoting *Park'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985)).

In considering the scope of preemption under ERISA, this Court has employed a three-part analysis that follows the language and structure of Section 514. *See, e.g., Pilot Life*, 481 U.S. at 45.<sup>6</sup> It is at the critical third step, the analysis of the deemer clause, where the Court of Appeals for the Third Circuit erred.

First, ERISA's broad preemption provision, Section 514(a), provides that ERISA shall preempt "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." § 514(a) of ERISA; 29 U.S.C. § 1144(a). "The phrase 'relate to' was given its broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.'" *Metropolitan Life*, 471 U.S. at 739 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). Both the district court and the court of appeals held that the Pennsylvania Legislature intended Section 1720 of the Financial Responsibility Law to apply to employee benefit plans and that, under the terms of Section 514 of ERISA, Section 1720 "relates to" benefit plans such as the Health Plan. (C8-C9); *FMC*, 885 F.2d at 84-85. Indeed, Section 1720's relation to and effect on the Health Plan is dramatic – it prohibits FMC from exercising its contractual and common law subrogation rights.

<sup>6</sup> The court of appeals belittled this Court's analysis of ERISA's preemption provisions as "[s]tating the obvious more than providing guidelines for surmounting [the] difficulties" in interpreting those provisions. *FMC*, 885 F.2d at 84.

Second, Congress sought uniform federal regulation of benefit plans but also faced the reality that preempting the area without exception would run afoul of its traditional deference to state regulation of the insurance industry. See McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.* (1976); see also *Metropolitan Life*, 471 U.S. at 743-44 (quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)). Thus, Congress created Section 514(b)(2)(A), the so-called insurance saving clause, which provides:

[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(A). The insurance saving clause does not allow the states to regulate directly the terms of employee benefit plans but rather preserves "the McCarran-Ferguson Act's reservation of the business of insurance to the states," *Metropolitan Life*, 471 U.S. at 744 n.21, by leaving to the states the regulation of *contracts of insurance* purchased by ERISA benefit plans.<sup>7</sup>

A state law "regulates insurance" if it meets the common sense requirement that it is specifically directed

<sup>7</sup> Congress' post-enactment understanding of the deemer clause is consistent with the view that states may regulate insurance products purchased by benefit plans but may not directly regulate the plans themselves. See H.R. Rep. No. 1785, 94th Congress, 2d Sess. 33, 48 (1977) ("[S]tate regulation of [insurance products] is not preempted by Section 514 even though such state action is barred with respect to the plans which purchase these 'products.'"); see also *Metropolitan Life*, 471 U.S. at 747 n.25 (relying upon the same report to discern congressional intent underlying the deemer clause).

toward some aspect of the insurance industry, or if it falls within the McCarran-Ferguson Act's definition of the business of insurance. *Pilot Life*, 481 U.S. at 48 (citing 15 U.S.C. §§ 1011 *et seq.*).<sup>8</sup> Both the district court and the court of appeals determined that the Financial Responsibility Law regulates insurance within the meaning of the insurance saving clause, and FMC does not contest this point on this appeal. See *FMC*, 885 F.2d at 86 (the Financial Responsibility Law's "coordination of benefits and antisubrogation provisions directly control the terms of insurance contracts").

Third, ERISA's deemer clause, Section 514(b)(2)(B), limits the scope of the insurance saving clause, providing:

Neither an employee benefit plan nor any trust established under such a plan, shall be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for the purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts.

29 U.S.C. § 1144(b)(2)(B). Thus, the deemer clause precludes the states from treating an employee benefit plan

<sup>8</sup> The three factors relevant to whether a practice falls within the "business of insurance" under the McCarran-Ferguson Act are "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Metropolitan Life*, 471 U.S. at 743, quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (emphasis in original).

as if it were engaged in the business of insurance.<sup>9</sup> This limitation has the effect of barring the states from applying directly to an employee benefit plan state insurance laws that are saved from preemption by the insurance saving clause. In other words, the deemer clause places self-funded plans, such as the Health Plan, entirely beyond the reach of state insurance regulation.<sup>10</sup> The court of appeals ignored the plain language of the deemer clause and, invoking the insurance saving clause, applied Section 1720 of the Financial Responsibility Law directly to the Health Plan, invalidating its subrogation rights.

**B. This Court's Decision in *Metropolitan Life* Recognized That ERISA Allows States to Regulate ERISA Benefit Plans Only Indirectly Through Regulation of Insurance Companies And Their Products.**

*Metropolitan Life* held that ERISA did not preempt a Massachusetts statute that required insurers, and thus insured employee health-care plans, to provide minimum mental-health-care benefits to Massachusetts residents. *Metropolitan Life*, 471 U.S. at 738-47.<sup>11</sup> This Court analyzed

<sup>9</sup> Black's Law Dictionary defines "deem" as follows:

**Deem.** To hold; consider; adjudge; believe; condemn; determine; *treat as if*; construe. Black's Law Dictionary 374 (5th ed. 1979) (emphasis added).

<sup>10</sup> On the other hand, insured benefit plans are subject to indirect regulation only because states may regulate the insurance products they purchase, not the plans themselves.

<sup>11</sup> Massachusetts conceded that the "mandated-benefits" statute at issue could not reach self-funded benefit plans in light of the deemer clause. *Id.* at 735, n.14.

the structure of Section 514 of ERISA, in particular the relationship between the insurance saving clause and the deemer clause. *Id.* at 740-41.

Specifically, the reach of the insurance saving clause was defined by reference to the purpose of the deemer clause:

[T]he deemer clause makes explicit Congress' intention to include laws that regulate [the terms of] insurance contracts within the scope of the insurance laws preserved by the saving clause. Unless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans.

*Id.* at 741 (emphasis added). Accordingly, state laws regulating the terms of insurance contracts, such as the anti-subrogation provision of the Financial Responsibility Law, are explicitly exempted "from the saving clause [and thus preempted by ERISA] when they are applied directly to benefit plans." *Ibid.*<sup>12</sup>

This Court concluded:

Our decision results in a distinction between insured and uninsured plans, leaving the former

<sup>12</sup> Section 1720 of the Financial Responsibility Law regulates the terms of insurance contracts as did the mandated benefits provision in *Metropolitan Life*: Section 1720 limits the provisions that may be included in insurance contracts whereas the Massachusetts statute required such contracts to include particular provisions.



open to indirect regulation while the latter are not. By so doing, we merely give life to a distinction Congress is aware of and one it has chosen not to alter.

*Id.* at 747 (footnote omitted). Thus, Pennsylvania may regulate the terms of insurance contracts, including those purchased by employee benefit plans. The antisubrogation provision of Section 1720 does just that. But Pennsylvania may not directly or indirectly regulate a self-funded employee benefit plan that does not purchase any insurance products. Contrary to the holding of *Metropolitan Life*, the court of appeals' decision erroneously permits Pennsylvania to encroach upon this federally preempted area.

**C. The Test Adopted By the Court of Appeals Contravenes This Court's Decision in *Metropolitan Life* and Is Inconsistent With The Weight of Appellate Authority.**

Since *Metropolitan Life*, seven courts of appeals have interpreted the deemer clause. With two exceptions, those courts have read *Metropolitan Life* and the deemer clause to mandate preemption of all state insurance laws as applied directly to self-funded plans.<sup>13</sup> Only the Courts of

<sup>13</sup> The courts of appeals are in conflict in their interpretation of the deemer clause: Compare *Baxter v. Lynn*, 886 F.2d 182, 186 (8th Cir. 1989) (noting that even if state subrogation law had been saved from preemption as a law that regulated insurance, the deemer clause of Section 514 clearly prevents application of the subrogation law to a self-funded benefit plan) and *Reilly v. Blue Cross and Blue Shield United of Wisconsin*,

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Appeals for the Third Circuit in *FMC* and the Sixth Circuit in *Northern Group Services Inc. v. Auto Owners Ins. Co.*, 833 F.2d (6th Cir. 1987), *cert. denied*, 108 S.Ct. 1754 (1988), have disregarded *Metropolitan Life*. Indeed, the Third

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846 F.2d 416, 425-26 (7th Cir.), *cert. denied*, 109 S.Ct. 145 (1988) (holding that, regardless whether plaintiff's state law claims fall within insurance saving clause, Section 514 of ERISA preempts those claims when made against self-funded benefit plan) and *Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 410-13 (3d Cir. 1987) (holding that Pennsylvania's mandated benefits law could not be applied to a self-funded benefit plan because it was preempted by ERISA) and *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1161-62 (9th Cir. 1986) (holding that Section 514 of ERISA prevents application of Arizona antisubrogation law to self-funded benefit plan) and *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419, 423 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (holding that Section 514 of ERISA prevents application of Virginia insurance trade practice laws to self-funded benefit plan) and *Children's Hosp. v. Whitcomb*, 778 F.2d 239, 242 (5th Cir. 1985) (holding that Section 514 of ERISA prevents application of a Louisiana mandatory benefits law to a self-funded benefits plan) with *FMC Corp. v. Holliday*, 885 F.2d 79, 89-90 (3d Cir. 1989), *cert. granted*, 110 S.Ct. 1109 (1990) (holding that Pennsylvania antisubrogation law as applied to self-funded benefit plan was not preempted by Section 514 of ERISA because the Pennsylvania law did not address "a core type of ERISA matter which Congress sought to protect by the preemption provision") and *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 89-93 (6th Cir. 1987), *cert. denied*, 108 S.Ct. 1754 (1988) (holding that Michigan coordination of benefits law as applied to self-funded benefit plan was not preempted by ERISA because there was no ERISA interest in uniformity which outweighed the interest in state regulation of insurance).

Circuit's decision in this case cannot be reconciled with a prior decision of the same court which interpreted the deemer clause to preempt state insurance regulations as applied to self-funded plans. See *Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 411 (3d Cir. 1987).<sup>14</sup>

In contrast to the decisions in *FMC* and *Northern Group Services*, the great majority of federal courts of appeals that have considered the application of state insurance laws to self-funded benefit plans has relied upon the deemer clause and the reasoning of *Metropolitan Life*; those courts have consistently held that state insurance law cannot reach self-funded employee benefit plans.

The decisions by the Courts of Appeals for the Eighth Circuit in *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989), and for the Ninth Circuit in *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986), are particularly apposite to this case. In *Baxter* and *Pacyga*, participants in self-funded benefit plans were injured in motor vehicle accidents, collected medical benefits from their plans and asserted claims for damages against third-party tortfeasors. *Baxter*, 886 F.2d at 184; *Pacyga*, 801 F.2d at 1158-59. In both cases, the employee benefit plans sought reimbursement of medical expenses paid on behalf of the plans' participants pursuant to subrogation provisions

<sup>14</sup> The *Muir* court noted that ERISA's preemption scheme allows states to regulate any entity engaged in the business of insurance but does not permit direct regulation of ERISA benefit plans. *Id.* at 411.

contained in the plans; the beneficiaries insisted that state law prohibitions against subrogation voided the plans' subrogation rights. *Baxter*, 886 F.2d at 184; *Pacyga*, 801 F.2d at 1159. In both cases, the courts of appeals, relying on *Metropolitan Life*, concluded that the deemer clause operated to prevent state antisubrogation laws from reaching self-funded benefit plans. *Baxter*, 886 F.2d at 186; *Pacyga*, 801 F.2d at 1161-62.

Although confronted with different factual circumstances, other federal appellate courts in the majority have reached the same fundamental conclusion: ERISA's broad preemption provision, Section 514(a), and the deemer clause, Section 514(b)(2)(B), operate to preempt state insurance laws as applied directly to self-funded employee benefit plans. For example, in *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986), a beneficiary of a self-funded plan sought damages for her employer's alleged breach of an implied covenant of good faith and fair dealing and for violations of the Virginia Unfair Trade Practice Act, both of which apply to insurers. *Id.* at 422. The court held that the deemer clause protected the employer from such claims. *Id.* at 423. Similarly, in *Reilly v. Blue Cross and Blue Shield of Wisconsin*, 846 F.2d 416 (7th Cir.), *cert. denied*, 109 S.Ct. 145 (1988), the court relied upon the deemer clause to hold that a plan beneficiary's state law claims for bad faith and punitive damages could not reach the self-funded plan at issue. *Id.* at 425-26. Finally, in *Children's Hosp. v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985), a state insurance statute required employers to structure their benefit plans to provide the same level of benefits for mental health problems and for all other illnesses. *Id.* at 241. Relying upon *Metropolitan Life*, the court determined

that the deemer clause prohibited application of this statute to self-funded plans. *Id.* at 242.

Despite the language of ERISA, despite *Metropolitan Life* and despite the great weight of authority from other courts of appeals, the Third Circuit applied the anti-subrogation provision of the Financial Responsibility Law to FMC's self-funded Health Plan and fashioned a new test that sharply limits the accepted meaning of the deemer clause and expands the reach of the insurance saving clause:

[T]he proper inquiry under the deemer clause is whether the state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the preemption provision. The court, reviewing a state insurance law, should inquire whether that law conflicts with any substitute (sic) mandate in ERISA.

*FMC*, 885 F.2d at 89-90. Notwithstanding its promulgation of this new test, the court of appeals acknowledged that the deemer clause, as interpreted in *Metropolitan Life*, requires courts to prohibit the application of at least some state insurance laws directly to self-funded plans. The court then turned its back on the *Metropolitan Life* interpretation of the deemer clause, labelling it "dicta," and held that "insured plans would *per se* survive the deemer clause, while self-insured plans would merely be considered on a case-by-case basis as to whether the state regulation involved affects a central concern of ERISA." *FMC*, 885 F.2d at 89.<sup>15</sup>

<sup>15</sup> In *Northern Group Services*, the Court of Appeals for the Sixth Circuit also acknowledged that the deemer clause

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The fundamental flaw in the reasoning in *FMC* is its determination that self-funded plans are, in fact, "in the business of insurance" for non-core ERISA matters and are thus subject to state insurance regulation. That premise flies in the face of the deemer clause's plain statement that an employee benefit plan is not to be deemed, for any purposes or at any time, to be engaged in the business of insurance. The Third Circuit's novel and unsupported presumption rests not on the strength of binding case authority or legislative history but on its stated desire to have ERISA's interlocking preemption provisions "make sense." *FMC*, 885 F.2d at 88. However, this Court's reading of the deemer clause in *Metropolitan Life* as a limitation on the reach of the insurance saving clause makes perfect sense of the statutory scheme and is entirely in accord with congressional intent.<sup>16</sup>

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requires courts to limit the application of state insurance laws to self-funded plans. *Northern Group Services*, 833 F.2d at 94-95. That court, however, fashioned yet another test to determine whether regulation of self-funded plans was preempted:

[I]n the absence of a showing of state purpose specifically to regulate the content of welfare benefits provided by ERISA, the effect of the deemer clause should be assessed by a balancing of the interests in federal uniformity against those of state primacy in the regulation of insurance.

*Id.* at 92-93.

<sup>16</sup> The *FMC* court underscored its refusal to apply the *Metropolitan Life* holding that state insurance laws may not be applied directly to self-funded plans by criticizing this

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Moreover, the test fashioned by the court of appeals in *FMC* is remarkably similar to the preemption test that was rejected in *Metropolitan Life*. This Court held there that "[n]othing in the language, structure, or legislative history of [ERISA] supports the [Massachusetts] Supreme Judicial Court's attempt to save only state regulations unrelated to the substantive provisions of ERISA." *Metropolitan Life*, 471 U.S. at 746-47. Similarly, nothing in the language, structure or legislative history of ERISA supports the attempt of the court below to preempt state regulation of self-funded benefit plans only where state laws affect a core type of ERISA matter or conflict with any substantive mandate in ERISA. *FMC*, 885 F.2d at 89-90.<sup>17</sup>

Thus, the deemer clause, as interpreted by this Court in *Metropolitan Life*, by the Third Circuit in *Muir*, and by the Fourth, Fifth, Seventh, Eighth and Ninth Circuits, prohibits the application of any state insurance law to a self-funded employee benefit plan. The court in *FMC* erred when it failed to apply this bright-line test.

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Court's opinion, stating that this Court had "cited neither statutory text nor legislative history" in reaching its conclusion regarding the scope of the deemer clause. *FMC*, 885 F.2d at 89.

<sup>17</sup> While the test rejected in *Metropolitan Life* related to the insurance saving clause, this Court's reasoning applies with full force to the test fashioned in *FMC*. Both the Supreme Judicial Court of Massachusetts and the Third Circuit sought to alter the scope of the saving clause, the former seeking to limit it, the latter seeking to expand it, through the vehicle of conflict-based tests. No justification exists for either attempt.

Moreover, as demonstrated below, it fashioned a preemption standard that is inconsistent with the legislative history of ERISA and fundamentally subversive of Congress' purposes in broadly preempting state regulation of employee benefit plans.

#### **D. The Court Of Appeals' Misreading Of ERISA's Legislative History Led To Unwarranted Restrictions On The Deemer Clause.**

The court of appeals relied on an unsupportable reading of ERISA's legislative history to reject the teaching of *Metropolitan Life*, expand the insurance saving clause and restrict the role of the deemer clause. The result is impairment of the general preemption mandated by Section 514(a). Under the court's novel test, states may deem self-funded plans to be engaged in the business of insurance for the purpose of regulating "non-core" aspects of plans, a concept for which there is not the slightest support in either ERISA or its legislative history.

Congress made the express preemption provisions of ERISA "deliberately expansive," and "House and Senate sponsors emphasized both the breadth and importance of the preemption provisions." *Pilot Life*, 481 U.S. at 45-46 (citations omitted). In fact, the bill's original preemption provision--limiting preemption "only to state laws relating to specific subjects relating to ERISA"--was changed to reflect Congress' desire to preempt the entire field with regard to benefit plans. *Shaw*, 463 U.S. at 98-99. In *Shaw*, this Court relied on that change to hold that Section 514(a) preempts *more than* "laws dealing with the subject

matters covered by ERISA – reporting, disclosure, fiduciary responsibility and the like.” *Id.* at 98.

In contrast to its creation of a sweeping general preemption provision, Congress, through the insurance saving clause, fashioned an exception to allow the states to maintain their historical power to regulate insurance coverage, while ensuring, through the deemer clause, that states could not expand this exception by treating benefit plans themselves as though they were insurance companies subject to state regulation. The court of appeals, in creating its deemer clause test, undermined the congressional will to make Section 514(a) expansive by erroneously narrowing the scope of preemption as applied to self-funded plans to situations where the state insurance regulation impinges on a “core” ERISA concern, such as “reporting, disclosure, and nonforfeitability.” *FMC*, 885 F.2d at 88. Nothing in ERISA or its legislative history suggests that Congress sought to expand the breadth of the insurance saving clause to the detriment of ERISA’s general preemptive scope, a result inherent in the court of appeals’ deemer clause test.

Moreover, in concluding that the deemer clause is limited to core ERISA concepts, the courts of appeals in *FMC* and in *Northern Group Services* revisited the same legislative history that led this Court to a contrary decision concerning the respective reach of the insurance saving and deemer clauses in *Metropolitan Life*. Compare *Metropolitan Life*, 471 U.S. at 745-46, nn. 23-24, with *FMC*, 885 F.2d at 87 and *Northern Group Services*, 833 F.2d at 93,

n.3. Nowhere in *Metropolitan Life* did this Court mention the concern so prominent in the *FMC* and *Northern Group Services* opinions, i.e., that by use of the deemer clause Congress sought to prevent only “back-door” or “pretextual” attempts by the states to regulate ERISA plans. See *FMC*, 885 F.2d at 86-88 and *Northern Group Services*, 833 F.2d at 92-93. In fact, the analysis of the legislative history undertaken by the Third and Sixth Circuits is incorrect.

The court below attached special significance to Congress’ use of the phrase “purporting to regulate” in the deemer clause, noting that “the use of ‘purporting’ betokens a congressional concern only for regulation that was merely a pretext for impinging upon ERISA plans.” *FMC*, 885 F.2d at 86-87. This construction is at odds with the ordinary meaning of the statutory language.<sup>18</sup> Laws which purportedly regulate insurance companies or contracts are merely laws which have the appearance or legal

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<sup>18</sup> Black’s Law Dictionary defines “purport” and “pretext” as follows:

**Purport**, n. Meaning; import; substantial meaning; substance; legal effect. The “purport” of an instrument means the substance of it as it appears on the face of the instrument, and is distinguished from “tenor,” which means an exact copy.

**Purport**, v. To convey, imply or profess outwardly; to have the appearance of being, intending, claiming, etc.

**Pretext**. Ostensible reason or motive assigned or assumed as a color or cover for the real reason or motive; false appearance, pretense.

Black’s Law Dictionary 1069, 1112 (5th ed. 1979) (citations omitted).

effect of regulating insurance companies or contracts. Congress' use of "purportedly" does not imply that the deemer clause was directed at deceit or surreptitiousness on the part of state legislatures.

Furthermore, the test devised by the Third Circuit does not correspond to the reasoning used to justify its adoption. The test does not simply eradicate pretextual use by state legislatures of insurance, banking or securities regulation for the purpose of regulating ERISA plans; it actually exempts all non-core matters, whatever they might be, from the scope of the deemer clause.

The court of appeals also relied on changes to the scope of ERISA's broad preemption section during the legislative process to justify its treatment of the deemer clause. This reliance is misplaced. The court noted that the first version of the deemer clause appeared in a bill which contained the original, narrow version of Section 514(a), *i.e.*, the version preempting only those state laws relating to the reporting, disclosure or fiduciary aspects of ERISA. *FMC*, 885 F.2d at 87. Thereafter, when the Conference Committee expanded Section 514(a) to preempt all state laws which relate to any employee benefit plan, it kept the deemer clause without change. *Id.* at 87-88. Because the deemer clause was virtually unchanged, the court below concluded that "retention of the deemer clause in the face of the expanded preemption clause indicates that the deemer clause in effect was meant to do the more narrow, specified work which the original version of the preemption clause was meant to do." *Id.* at 88.

That conclusion defies logic. Congress' revisions to Section 514(a) have no bearing on the meaning of the deemer clause, the purpose of which, as made clear by this Court in *Metropolitan Life*, is to define and limit the scope of the insurance saving clause. In fact, the Courts of Appeals for the Third and Sixth Circuits have misconceived the purposes of Congress, leading them to an incorrect and undesirable result.

#### **E. Enforcing The Deemer Clause As A General Limitation On The Insurance Saving Clause Furthers The Purposes Of ERISA.**

The many benefits which Congress sought to achieve through its enactment of a broad preemption provision are preserved by the deemer clause's limitation on the insurance saving clause.

First, Congress established benefit plan regulation as exclusively a federal concern to minimize the need for interstate employers such as FMC to structure and administer their plans differently in each state in which they have employees. *Shaw*, 463 U.S. at 105.<sup>19</sup> Congress recognized the administrative realities of employee benefit plans and sought to promote an employer's capacity to

<sup>19</sup> See also 120 Cong. Rec. 29942 (1974) (statement of Senator Jacob Javits) ("[T]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required - but for certain exceptions - the displacement of State action in the field of private employee benefit programs") and 120 Cong. Rec. 29933 (1974) (statement of Sen. Harrison Williams, Jr.) (preemption of the field intended to apply in its broadest sense with only the exceptions specified in the act).



provide benefits to employees scattered throughout many states in the most efficient manner, *i.e.*, through a single employee benefit plan. *Id.* at 105 n.25. As this Court stated in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987):

It is thus clear that ERISA's preemption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Preemption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

*Id.* at 11.

The court of appeals' holding subjects benefit plans to conflicting or inconsistent state laws at great costs to the plans – and at the ultimate expense of plan participants and beneficiaries.<sup>20</sup> Indeed, FMC's Health Plan has already been subjected to conflicting decisions regarding

<sup>20</sup> The court of appeals' opinion paves the way for a direct assault on the cost-containment efforts of self-funded plans, such as the Health Plan. That Plan contains costs through subrogation. The inability to exercise this contract right, because of the Financial Responsibility Law's antistubrogation provision, may force the Health Plan to reduce benefits to participants and beneficiaries. Congress feared this very scenario and drafted ERISA's preemption provisions with a broad brush to prevent its occurrence.

the application of state antistubrogation laws. A district court in California held, in direct conflict with this case, that a California antistubrogation statute is preempted as applied to FMC's Health Plan. *See FMC Corp. v. Good Samaritan Hosp. of the Santa Clara Valley*, No. C-88-3092-FMS (N.D. Cal. 1988) (D1). It is precisely the burden of having to comply with multiple and conflicting insurance regulations that ERISA's preemption provisions are intended to avoid. *See Fort Halifax*, 482 U.S. at 10.

Second, Congress believed that ease of administration resulting from nationally uniform regulation encourages employers to establish benefit plans without sacrificing protection of plan participants and beneficiaries.<sup>21</sup> Elimination of conflicting and inconsistent regulation encourages the establishment of plans by reducing their administrative and litigation costs. *Id.* at 11. However, this incentive for employers did not come at the expense of plan participants and beneficiaries. Plan participants and beneficiaries are protected by the reporting, disclosure and fiduciary requirements of ERISA, *see* 29 U.S.C. § 1001(b), and by the economic realities of the employer-employee relationship. *See Goetz, Regulation of*

<sup>21</sup> *See* Staff of Senate Comm. on Labor and Public Welfare, 94th Cong. 2d Sess., *reprinted in* Legislative History of ERISA 4670 (Comm. Print 1976) (statement of U.S. Rep. John Dent) ("I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent state and local regulation.").

*Uninsured Employee Welfare Plans Under State Insurance Laws*, 1967 Wis. L. Rev. 319, 345 (1967). Thus, application of state insurance statutes directly to benefit plans frustrates congressional goals without returning any real benefits to plan participants.

Finally, the clarity of the rule which limits states to regulation of insurance products and insurance companies and which prevents states from regulating the plans themselves will substantially reduce the likelihood of litigation concerning the validity of state action.<sup>22</sup> Congress rejected a case-by-case approach with respect to Section 514(a) because "it raised the possibility of endless litigation over the validity of state action that might impinge on Federal regulation." *FMC*, 885 F.2d at 88 (quoting Senator Javits).<sup>23</sup> The vague, case-by-case tests of the Third and Sixth Circuits invite precisely the type of endless litigation that ERISA's drafters sought to

<sup>22</sup> The large number of courts that have struggled with the issue of application of state insurance regulation directly to benefit plans demonstrates the need for a bright-line rule governing the issue. See, e.g., note 13, *supra*.

<sup>23</sup> Senator Javits, one of the architects of ERISA, explained that Congressmen viewed earlier versions of House and Senate bills defining the perimeters of preemption in relation to the areas regulated by ERISA as problematic since "[s]uch a formulation raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." 120 Cong. Rec. 29942 (1974).

preclude.<sup>24</sup> If the holding below is allowed to stand, much ingenuity will be brought to bear by future advocates on the subject of which matters are core ERISA concerns and which are not.

If the "core ERISA matter" test were to be adopted, plan administrators would be burdened with ascertaining, for each state in which covered employees reside, which insurance regulations may be applicable to their plans and which of those regulations implicate core ERISA concerns.<sup>25</sup> Adding to this substantial and costly burden is the fact that the Third Circuit's core concern test provides scant guidance upon which plan administrators and participants may base their everyday decisions regarding the applicability of state insurance regulation. Ultimately, plan administrators and participants will repeatedly resort to the courts for that guidance, thus frustrating Congress' efforts to discourage

<sup>24</sup> The malleability of the case-by-case approach is vividly illustrated by the Sixth Circuit's decision in *Liberty Mutual Ins. Group v. Iron Workers Health Fund of E. Michigan*, 879 F.2d 1384 (6th Cir. 1989), where the Sixth Circuit applied the test set forth in *Northern Group Services* but reached an opposite conclusion regarding the preemption of the same Michigan insurance statute that was at issue in *Northern Group Services*. See *Liberty Mutual*, 879 F.2d at 1387-88.

<sup>25</sup> On the other hand, insurers providing insurance policies to benefit plans would not be burdened with the task of determining which insurance regulations implicate core ERISA concerns because state insurance regulations are always applicable to their policies.

litigation over the permissible scope of state regulation. The bright-line rule established by ERISA itself and articulated in *Metropolitan Life* makes such litigation unnecessary.

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### CONCLUSION

Congress expressly rejected an opportunity to preempt only those state laws which conflict with core ERISA concerns when it enacted Section 514(a). Accordingly, in *Shaw*, this Court recognized Congress' decision and rejected an attempt to limit preemption under Section 514(a) only to those "laws dealing with subject matters covered by ERISA - reporting, disclosure, fiduciary responsibility and the like." *Shaw*, 463 U.S. at 98. Similarly, in *Metropolitan Life* this Court rejected an interpretation of the insurance saving clause that saved from preemption "only state laws that were unrelated to the substantive provisions of ERISA." *Metropolitan Life*, 471 U.S. at 736. Now, yet another judicial incarnation of the same conflict-oriented test has arisen, only this time it is the deemer clause that is at issue and the test takes the form of "core ERISA concerns." Like other conflict-oriented tests previously rejected by this Court, this latest variant must also be dismissed. The decision of the Court of

Appeals for the Third Circuit should be reversed, and judgment should be entered in favor of FMC.

Respectfully submitted,

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In The  
**Supreme Court of the United States**  
October Term, 1989

**FMC CORPORATION**

*Petitioner,*

**vs.**

**CYNTHIA ANN HOLLIDAY**

*Respondent.*

On Writ Of Certiorari To The United States  
Court Of Appeals For The Third Circuit

**BRIEF FOR RESPONDENT**

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## COUNTERSTATEMENT OF THE CASE

Cynthia Ann Holliday's father was an employee of FMC. Owing to her father's enrollment in FMC's Salaried Health Plan, Ms. Holliday enjoyed coverage for medical expenses pursuant to the terms of the Plan. (J.A. 4-5). Ms. Holliday, then age 15, was injured catastrophically in an automobile collision in White Township, Pennsylvania, on January 16, 1987. Ms. Holliday suffered, *inter alia*, a depressed skull fracture causing severe brain swelling and permanent brain damage affecting her motor and cognitive functions. (J.A. 84). Medical care rendered for these injuries, as of January 18, 1988, cost a total of \$178,626.11. (J.A. 113-119). The extent and permanency of her injuries, coupled with her youth, assured that the cost of future care will be substantial.

The Plan provides for coordination of benefits between first-party automobile coverage and the Plan as follows:

If you or a covered member of your family are eligible to receive benefits under another group medical plan, Health Maintenance Organization (HMO), government plan, or by "no-fault" automobile insurance which provides medical coverage, you may be eligible for benefits from those Plans and your FMC Plan. In the case of coverage by "no-fault" automobile insurance, FMC will pay covered expenses not paid for by no-fault insurance. (J.A. 62-63).

*No-Fault*

In some states with no-fault motor vehicle coverage, the carrier is the primary insurer in these jurisdictions. All medical expenses related to an accident must be submitted to the carrier and not the FMC Health Care Plan. Eligible expenses not paid for by no-fault insurance *will* be paid by the FMC Plan. (J.A. 68).

(App. 62A)

Under the coordination of benefits and "no-fault" provision of the Plan, the first \$10,000.00 in medical bills

were paid by the State Farm Mutual Automobile Insurance Company under a motor vehicle insurance policy owned by Mr. Holliday on the date of the accident. (J.A. 134). The Plan availed itself of the coordination of benefits and no-fault clauses, commencing payment of medical bills only after State Farm's coverage was exhausted. Although the Complaint filed by Petitioner in the District Court alleged that the Plan had expended "approximately \$105,000.00 in benefits" for Ms. Holliday (J.A. 5), its Affidavit in Support of Summary Judgment conceded the true amount of "approximately \$67,768.00". (J.A. 106). Although Ms. Holliday's medical bills were well in excess of the \$100,000.00 threshold required for eligibility under the Pennsylvania Catastrophic Loss Trust Fund, Act of February 12, 1984, P.L. 26, 11-12, 75 Pa.C.S.A. Sections 1761-1769, (App. 223A-2224A), and the Plan provides a one million dollar lifetime maximum per person (J.A. 55), the Plan paid no expenses which qualified for Catastrophic Loss Trust Fund coverage.

The Plan does contain a clause which reserves to itself full subrogation rights. (J.A. 68-69.) The subrogation clause is mandatory, and written "consent" to its mandate is a condition precedent to receipt of benefits. *Ibid.* The claim and subrogation provisions were administered on behalf of FMC by the Equitable Life Assurance Society of the United States, or by one of its affiliate agencies. (J.A. 79, 120.) Mr. Holliday then commenced the civil action as described in Petitioner's brief. Unfortunately, several other individuals suffered injuries of various degrees of severity. Ms. Holliday was thus forced to share \$100,000.00 (the only liability insurance proceeds available) with these other claimants. (J.A. 123-125.) On May 2, 1989, an Order was entered approving a settlement by and between Ms. Holliday, three other individuals who made claim against the liability insurance proceeds in response to the interpleader, and the tortfeasor, the effect of which is to limit Cynthia Ann Holliday's recovery from the tortfeasor to \$49,875.50, plus accrued interest. (Brief for Petitioner, p. 6, n. 3.)

FMC notified Mr. Holliday of its intent to exercise subrogation rights with respect to these funds. The Statement of Facts set forth on pages seven and eight of the Petitioner's Brief fairly summarizes the circumstances which followed such notice.

### SUMMARY OF ARGUMENT

The clear language of ERISA contains no mandate that state anti-subrogation laws be preempted as applied to self-funded employee welfare benefit plans. Other sections of ERISA demonstrate that Congress' purpose in enacting that statute was to assure integrity and national uniformity in the day-to-day funding and administration of plans, not to allow plans to operate without incidental constraints imposed by state law.

Nor does ERISA's legislative history reveal that Congress intended to preempt laws such as Pennsylvania's anti-subrogation statute when it enacted §514. The legislative history is consistent with the previously described objects and policies of Congress, none of which suggests that Congress intended to obliterate all state laws as applied to self-funded employee welfare benefit plans.

The decisions of this Court interpreting ERISA §514 have consistently sought the aims to be achieved by Congress in enacting ERISA, and have analyzed not only the language of §514 itself, but also the language of the entire statute. This Court has never held that all self-funded employee welfare benefit plans are exempt from all state insurance laws by virtue of the "deemer" clause. The lower courts' ruling is consistent with the prior holdings of this Court addressing the scope of §514.

Reversal of the lower court will not further any of the substantive policy underlying ERISA, as obliteration of state anti-subrogation insurance laws as applied to self-funded plan will not relieve plan fiduciaries of substantial, day-to-day administrative burdens or reduce the risk of enforcement of state remedies against the plans. Such a



result would, however, seriously damage the states' ability to manage insurance in tort matters within their own borders, risking chaos in the automobile tort system and depriving plan participants of just recoveries.

### ARGUMENT

#### I. THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 DOES NOT PREEMPT THE PENNSYLVANIA MOTOR VEHICLE FINANCIAL RESPONSIBILITY LAW OF 1984.

##### A. The statutory language documents Congress' intent to forego preemption of all state insurance laws.

Petitioner and the Solicitor General espouse the position that ERISA §514 justifies a blanket eradication of all state laws affecting self-funded employee welfare benefit plans. Such a position cannot withstand a careful analysis of the language or history of the statute.

The essence of federal preemption analysis is the discovery of Congressional intent to preempt. *Metropolitan Life Insurance Company v. Commonwealth of Massachusetts, et al.*, 471 U.S. 724, 738 (1985), (quoting *Mallone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)). This Court has always presumed that Congress does not intend to preempt areas of traditional state regulation. *Metropolitan Life*, 471 U.S. 724, 749 citing *Jones v. Rath Packing Company*, 430 U.S. 519, 525 (1977).

The Court is now well familiar with the preemption clause of ERISA:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

29 U.S.C. §1144(a)

(A) Except as provided in subparagraph (b), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any state purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. §1144(b)(1)-(2).

This Court employs a tripartite test which parallels the three provisions of §514. First, it is determined whether the state law "relates to" an employee benefit plan. If not, it is not preempted. If so, it must be determined whether the state law regulates insurance. Finally, the state law must survive the so-called "deemer" clause of §514(b)(2). *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 46 (1987).

The Pennsylvania Motor Vehicle Financial Responsibility Law, Act of February 12, 1984, P.L. 26, #11, §3, as amended by Act of February 12, 1984, P.L. 53, #12, §3, 75 Pa.C.S.A. §1701, *et seq.*, was the Pennsylvania Legislature's second effort to streamline the full tort system utilized by Pennsylvania in motor vehicle accident cases since the discovery of internal combustion.<sup>1</sup> The law

<sup>1</sup> The Pennsylvania No-Fault Motor Vehicle Insurance Act, the Act of July 19, 1974, P.L. 489, #176, 40 Pa.C.S.A. §109.1 *et seq.*, was repealed by the Motor Vehicle Financial Responsibility Law. While the No-Fault law was the first attempt by



established minimum mandatory benefits for auto policies<sup>2</sup>, coordinated benefits among various competing sources of recovery<sup>3</sup>, provided for a limited abolition of tort rights with respect to certain types of damages<sup>4</sup>, compelled the sale of underinsured and uninsured motorist insurance<sup>5</sup>, and provided for a state fund to cover the medical expenses of the most critically injured of motor vehicle victims<sup>6,7</sup>.

Congress has on several occasions acknowledged the states' fundamental right and interest in governing such insurance matters within their own borders. Most pertinent, of course, is the language of §514(b)(1) in which Congress so definitely exempted state insurance laws

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(Continued from previous page)

the Pennsylvania Legislature to modify the tort recovery system, it had regulated casualty insurance for many years prior to 1974. See, e.g., Act of May 17, 1921, P.L. 682, Article XI, 40 P.S. §341, *et seq.*

<sup>2</sup> 75 Pa.C.S.A. §1711-1712.

<sup>3</sup> 75 Pa.C.S.A. §1719.

<sup>4</sup> 75 Pa.C.S.A. §1722.

<sup>5</sup> 75 Pa.C.S.A. §1731.

<sup>6</sup> 75 Pa.C.S.A. §1761 *et seq.*

<sup>7</sup> The Motor Vehicle Financial Responsibility Law itself has been radically amended to address difficulties perceived by both plaintiffs and insurers. Act 6 of 1990, H.B. 121, approved February 7, 1990. This enactment has created a firestorm of controversy, pleasing almost no one and resulting in heated litigation between the Pennsylvania Insurance Department, motor vehicle insurers, and various health care providers, in both state and federal court, alleging the unconstitutionality of various sections of the law and challenging the right of casualty insurers to stop writing policies in Pennsylvania.

from §514(a) preemption that it utilized the word "any" on three occasions in the same sentence.<sup>8</sup>

An earlier, profound recognition of state primacy in the field of insurance is the McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U.S.C. §1011, *et seq.* Congress therein specifically provided that no federal law should be read to preempt any state law "regulating the business of insurance".<sup>9</sup> This Court has recognized Congress' intentions in this regard, particularly in the field of ERISA preemption. See *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. at 736-737.

Against this backdrop of Congressional policy in favor of preservation of state insurance laws, we now turn to the analysis of §514 as it applies to the anti-subrogation provision of Pennsylvania's Motor Vehicle Financial Responsibility Law.

Petitioner contends, and the Court below determined, that §1720 "relates to" employee benefit plans. Brief of Petitioner, page 11; *FMC Corp. v. Holliday*, 885

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<sup>8</sup> Although certain legislators characterize the exceptions to ERISA preemption as "narrow", the breadth of the language employed in §514(b)(1) leaves little room for doubt that the savings effect is all-encompassing. See also *Metropolitan Life*, 471 U.S. at 741 ("The presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope.")

<sup>9</sup> The legislative history of this Act documents the depth and breadth of the state interest in regulation of insurance matters. See Senate Report No. 20, 79th Cong., 1st Session, P. 1 "From its beginning the business of insurance has been regarded as a local matter, to be subject to and regulated by the laws of the several states. This view has been fostered and augmented by decisions of the United States Supreme Court for a period of more than 75 years, leading to the generally accepted doctrine that the business of insurance was not subject to federal law."

F.2d at 84-85.<sup>10</sup> The "relate to" issue has been fully addressed by the Brief filed by the National Conference of State Legislatures et al., as Amicus Curiae in support of Respondent. Id., page 5, N. 2. Respondent urges the Court to consider and adopt the "relate to" analysis as supplied by the National Conference.

All parties are in agreement with the lower courts' determination that the Pennsylvania Motor Vehicle Financial Responsibility Law generally, and its anti-subrogation clause in particular, "regulates insurance" as this Court has defined that term. *Metropolitan Life*, 471 U.S. at 741-744.

Should the Court conclude that MVFR §1720 "relates to" the FMC Plan and given the unanimity of opinion that §1720 is an insurance statute, we now reach the most perplexing aspect of §514, the meaning of the "deemer" clause. The Petitioner and the Solicitor General urge the adoption of a so-called "bright line" test for interpretation of the "deemer" clause. This interpretation would result in the total freedom from state insurance regulation of any self-funded employee welfare benefit plan. Such an interpretation is supported by neither the wording of the statute nor its legislative history.

Although Petitioner refers to the so-called "plain language" of the "deemer" clause, Brief for Petitioner at 14,

<sup>10</sup> Although not briefed extensively in the lower court by the Respondent, the issue is properly before this Court. The tripartite test renders the "relate to" question part of the "Question Presented" as defined on page i of the Petitioner's Brief. Further, it was submitted to the lower court by the brief filed by the Pennsylvania Trial Lawyers Association as Amicus Curiae on behalf of Respondent, and Respondent urged the lower court to consider this issue. Brief for Appellee, p. 17, n. 2. This Court has always considered questions passed on by the courts below no matter how extensively argued by the parties. See, e.g. *Sabbath v. United States*, 391 U.S. 585 (1968); *Jenkins v. Georgia*, 418 U.S. 153 (1974). And, this Court may base its opinion upon any ground supported by the record. *Chevron, USA, Inc. v. Natural Resources Defense*, 467 U.S. 837, 842, N. 7 (1984).

this Court has previously (and politely) recognized that the preemption provisions of ERISA "perhaps are not a model of legislative drafting". *Metropolitan Life*, 471 U.S. at 739. Several common sense observations as to what the "deemer" clause does *not* say are therefore an appropriate launching point for our analysis.

First, the "deemer" clause does *not* say, in so many words, that *no* state insurance law may in any way affect or limit the conduct of a self-funded plan or its fiduciaries. Had Congress intended to adopt this sweeping view, it could have simply drafted §514(b)(2) to read, "No state law regulating insurance shall be saved from preemption insofar as such law has any effect upon a self-funded employee welfare benefit plan." As this Court will assume that "the ordinary meaning of (Congress') language accurately expresses the legislative purpose", *Metropolitan Life*, 471 U.S. at 740 (quoting *Park 'N Fly, Inc. v. Dollar Park 'N Fly, Inc.*, 469 U.S. 189, 194 (1985)), so too should the absence of certain language indicate the absence of a clear legislative purpose which would have been expressed by such language.

Nor does the "deemer" clause in any way express Congress' intent with respect to state subrogation rules. Indeed, one cannot tell from the face of the statute whether Congress gave any thought to such laws in enacting ERISA. The law of subrogation is one which has traditionally been developed through state courts and legislatures. Since Congress must be presumed to have intended not to preempt traditional areas of state concern, *Metropolitan Life*, 471 U.S. at 740, the Court must presume that Congress did not formulate a specific intent to remove statutes such as §1720 from the effect of the "deemer" clause.

Petitioner and the Solicitor General narrow their arguments to focus upon the "deemer" clause itself. While the clause is the obvious starting point for review, this Court's customary approach to statutory interpretation must be minded:



On numerous occasions we have noted that " ' ' [i]n expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.' " " *Kelly v. Robinson*, 479 U.S. 36, 43 (1986), quoting *Offshore Logistics, Inc. v. Tallentire*, 477 U.S. 207, 221 (1986) (quoting *Mastro Plastic Corp. v. NLRB*, 350 U.S. 270, 285 (1956) (in turn quoting *United States v. Heirs of Boisdore*, 8 How. 113, 122, 12 L.Ed. 1009 (1849))). *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, at 51 (1987).

Thus, in *Pilot Life*, this Court eschewed a "knee-jerk" preemption argument, and examined in great detail the civil enforcement provisions of ERISA before concluding that preemption of state tort and contract remedies against plan fiduciary was intended by Congress. See 481 U.S. at 51-57.

Several provisions of ERISA shed light on Congress' intent with regard to the scope of regulation and preemption. Perhaps the most fundamental of these provisions is that which defines "employee welfare benefit plan":

The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship

funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions). 29 U.S.C. §1002(1) (Emphasis added.)

Congress' definition of "employee welfare benefit plan" without regard to its insured status is a clear signal that the "deemer" clause was *not* intended to form a blanket preemption of all state insurance laws as applied to self-funded employee welfare benefit plans. Congress would hardly have defined such plans with a specific prohibition against differentiation between insured and self-insured plans, while later proceeding to make such a differentiation through the use of the obtuse language of the "deemer" clause.

Petitioner and the Solicitor General also turned their backs on the "object and policy" aspects of the statutory interpretation. ERISA's initial clause sets forth at length the objects and policies which Congress attempted to address and implement by enacting this statute.<sup>11</sup>

There is no mention whatsoever in this clause of the need to provide special protection to self-funded employee welfare benefit plans from a form of state regulation which Congress considered so crucial as to be exempted specifically from preemption. Congress was clearly concerned with the financial integrity of employee benefit plans so that participants would be protected from plans which contained inadequate funding, vesting and termination insurance provisions. The declared policy of Congress was to provide for adequate disclosure, fiduciary standards, federal court remedies, minimum funding standards, and plan termination insurance. 29 U.S.C. §1001(b)-(c). Nowhere in its declaration of policy does Congress indicate that financial soundness of plans is to be achieved through blanket preemption of traditional state regulations, or by the grant to plan fiduciaries

<sup>11</sup> See 29 U.S.C. §1001.



of such revenue enhancement means as might suit their fancies. §1001 teaches that Congress sought to guarantee *capable, not unfettered, plan management.*

Moreover, the legislative history lends little or no support to the position taken by the Petitioner and the Solicitor General. There is nothing in official, contemporary legislative history which directly or indirectly notes that the "deemer" clause was intended to exempt all self-funded plans from the effects of all state insurance laws. Certainly, given the drastic effect which such Congressional action would have upon state regulation of insurance, such a startling departure from long-settled policy would have been the subject of express commentary, if not heated debate, if it had been intended by Congress. In view of the complete absence of any legislative history regarding the meaning of the "deemer" clause and the rationale behind the use of the word "deemed", Petitioner and the Solicitor General attempt to infuse an artificial meaning by reference to broad comments attributable to individual legislators in contexts not focused upon the "deemer" clause. See e.g. Brief for Petitioner at 27, Note 19, Page 30, Note 23; Brief of the Solicitor General, Page 14, Note 9. This Court has previously recognized, however, that such comments are of little use in ferretting out Congressional intent. *Metropolitan Life*, 471 U.S. at 746, N. 24.<sup>12</sup>

<sup>12</sup> Petitioner and the Solicitor General also refer to the ERISA Oversight Report of the Pension Task Force of the Subcommittee on Labor Standards, House Committee on Education and Labor (1977) as additional evidence of Congress' belief that the "deemer" clause would exempt self-funded plans from all forms of state insurance regulation. This report was, of course, issued several years after ERISA's enactment; its opinions are virtually meaningless in the debate over earlier Congressional intent. See e.g. *Mackey v. Lanier Collection Agency and Service*, 486 U.S. 825, 839-840 (1988). The report is also out of sync with the entire structure of the preemption clauses of

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Since the "deemer" clause cannot be afforded the broadstroke meaning urged by Petitioner and the Solicitor General, we now address what the "deemer" clause *does* mean. Several alternative explanations for the meaning of the clause do exist, and comport more readily with ERISA's regulatory scheme than those advanced by Petitioner and the Solicitor General.

One alternative is to view the "deemer" clause as having been intended to exempt self-funded plans from the "business" end of insurance obligations, such as capitalization and reserves. The Amicus Brief filed by the National Conference of State Legislatures et al., thoroughly discusses this approach to the "deemer" clause. *Id.* at 9-21. This discussion will not be repeated verbatim here, but is incorporated by reference into this Brief.

A closely related explanation of the "deemer" clause is that supplied by the Court below and by the Sixth Circuit Court of Appeals in *Northern Group Services v. Auto Owners' Insurance Company*, op. cit. The *Northern Group Services* analysis is particularly incisive, in that it carefully reviews the legislative history (such as it is) previously discussed in the briefs of the Petitioner, the Solicitor General and the National Conference, concluding:

Certain aspects of the legislative history imply that a main concern of Congress in adopting the final broad version of §514 that emerged from the Conference Committee was to avoid intentional – and perhaps pretextual – attempts by states to restrict the discretion of ERISA plans to engage in practices that would otherwise be permitted by federal law. See *American Progressive*

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ERISA. See *Northern Group Services v. Auto Owners' Insurance Company*, 833 F.2d 85, 89 (6th Cir. 1987), *Id.* at 92, citing *Consumer Product Safety Commission v. GTE Sylvania*, 447 U.S. 102, 117-118, and N. 13, (1980).

*Life and Health Insurance Company v. Corkran*, 715 F.2d 748, 787 (2d Cir. 1983). 833 F.2d at 93. See also *Id.*, N. 3.

This reading of the "deemer" clause does not require a finding that a state legislature has acted surreptitiously or maliciously to usurp federal power. Rather, it is broad enough to encompass intentional efforts by state legislators to encroach upon federal regulation of pension plans. The scope of preemption would then be defined by the "object and policy" analysis utilized by this Court in preemption cases. See, e.g., *Pilot Life*, op. cit.<sup>13</sup> Although condemned by Petitioner and the Solicitor General, the "core concerns" language utilized by the court below says no more than that §514 preempts only those state laws which conflict with ERISA's objectives and

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<sup>13</sup> Senator Jacob Javits, who is quoted by both the Petitioner and the Solicitor General, shed some light on the scope of preemption with the following comments:

"In view of federal preemption, state laws compelling disclosure from private welfare or pension plans, imposing fiduciary requirements on such plans, imposing criminal penalties on failure to contribute to plans – unless a criminal statute of general application – establishing state termination insurance programs, etc., will be superceded." 120 Congressional Record 29,942, reprinted in 3 Legislative History of the Employee Retirement Income Security Act of 1974, at 4771. While the use of "etc." indicates that Senator Javits did not intend this list to be exhaustive, it further suggests that he intended the list to be representative of the types of state laws to be preempted. Nothing here suggests that Senator Javits contemplated the scope of preemption suggested by Petitioner and the Solicitor General; in fact, the Senator's comments dovetail with the concerns expressed in §1001.

policies.<sup>14</sup> This is precisely how this Court expects the Circuit Courts of Appeals to conduct preemption analysis.

**B. The decision of the court below is consistent with this Court's interpretation of §514.**

Notwithstanding the arguments posited by the Petitioner and the Solicitor General, Respondent submits that the conduct of the Court below is entirely consistent with this Court's earlier treatment of the preemption clause.

For example, in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), this Court was asked to decide whether §514 preempted a New Jersey statute forbidding ERISA-based pension plans from offsetting benefits by any amounts received by participants from workers' compensation.<sup>15</sup> And in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983), this Court invalidated the New York Human Rights Law and Disability Benefits Law, insofar as they required plans to pay benefits to employees on pregnancy leave. But neither *Alessi* nor *Shaw* addressed the interface of the insurance savings and "deemer" clauses.<sup>16</sup>

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<sup>14</sup> The Sixth Circuit couched its holding in *Northern Group Services* in terms of the federal interest in national uniformity and the state regulatory program generally applicable to both insured and self-insured ERISA plans. 833 F.2d at 95. This approach is consistent with the "object and policy" analysis employed by this Court. The difference is, again, pure semantics.

<sup>15</sup> In so doing, this Court touched upon an ERISA policy overlooked by the Petitioner and the Solicitor General, i.e., that benefitting employees was a "primary goal" of ERISA, while containing pension costs was a "subsidiary" goal. 451 U.S. at 516. The Court recognized *en passant* the explicit nature of the insurance savings clause. 451 U.S. at 523, N. 19.

<sup>16</sup> *Shaw* was a golden opportunity for adoption of a blanket test that any law which affected a plan was preempted, but the Court did not do so because New York's action "plainly (did) not present a borderline question . . .". 463 U.S. 100, N. 21.



Moreover, the *Shaw* Court was not required to confront the question of whether a state law which was within a so-called "traditional area of state concern", in light of the history of shared authority between federal and state governments in the area of employment discrimination which does not parallel that of insurance regulation.<sup>17</sup>

Perhaps no decision of this Court is more important to the current controversy than *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985). This case arose from the efforts of several insurance companies to avoid Massachusetts' mandated benefits law as applied to health insurance policies sold to employee welfare benefit plans. In rejecting the insurer's claims, this Court had an opportunity to evaluate and review the effects of the insurance savings clause and the "deemer" clause upon insurance companies.<sup>18</sup>

In reaching its conclusion, the *Metropolitan Life* Court acknowledged its presumption "that Congress did not intend to preempt areas of traditional state regulation",

<sup>17</sup> Compare Title 7, Civil Rights Act of 1964, as amended, 42 U.S.C. §2000(e) et seq. with the Pennsylvania Human Relations Act, Act of October 27, 1955, P.L. 744, §1, as amended, 43 P.S. §951 et seq.

<sup>18</sup> Petitioner and the Solicitor General make much of Massachusetts' failure to attempt to enforce its mandated benefit law directly against an ERISA plan, and Massachusetts' concession "that such an application of (the mandated benefit law) would be preempted by ERISA's preemption clause," §514(a), 29 U.S.C. §1144(a). *Metropolitan Life*, 471 U.S. at 735, N. 14. Of course, Massachusetts' position does not bind Respondent in this case, and effectively removed any precedential value which *Metropolitan Life* might have had here. And, as will be discussed later in this Brief, a clear distinction may be made between a state's effort to enforce its mandated benefit law against a self-funded plan and a participant's reliance upon the state law of insurance remedies to prevent a self-funded plan from enforcing a unilaterally-imposed contractual term.

471 U.S. at 740, and indicated that "the presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope." 471 U.S. at 741. The Court proceeded to review the preemption clause's legislative history, noting that:

"(t)he preemption clause apparently was broadened out of the fear that 'state professional associations' would otherwise hinder the development of such employee benefit programs as 'prepaid legal service programs.'" See 120 Cong. Rec. 29197 (1974) (Remarks of Representative Dent); id. at 29933 (Remarks of Sen. Williams); id. at 29949 (Remarks of Sen. Javits). There is no suggestion that the preemption provision was broadened out of any concern about state regulation of insurance contracts, beyond a general concern about "potentially conflicting state laws." See id., at 29942 (Remarks of Sen. Javits). 471 U.S. at 745, N. 23. By contrast, "(t)here is no discussion in that history of the relationship between the general preemption clause and the saving clause, and indeed very little discussion of the saving clause at all." Id.; see also *ibid*, N. 22.

The Court found that *Shaw v. Delta Airlines, Inc.*, was "of little help" in interpreting the saving clause because "the saving clause is broad on its face and specific in its reference". 471 U.S. at 746, N. 24. The Court rejected the carrier's attempt to narrow the scope of the saving clause through citation of various comments made by Representative Dent and Senators Williams and Javits, most of which have been cited by Petitioner and the Solicitor General in support of their broad reading of the "deemer" clause. *Ibid*. To suggest that such comments strongly support an expansive reading of the "deemer" clause when this Court has already determined that they are too "frail" to support a narrow reading of the insurance saving clause is to defy logic.



Respondent certainly recognizes the Court's comments regarding the distinction between insured and uninsured plans. 471 U.S. at 474. As the Solicitor General concedes, this Court's observation was not central to its holding. Brief for the Solicitor General, p. 17.<sup>19</sup> This Court has never considered its dicta to be any part of its holding. *McDaniel v. Sanchez*, 452 U.S. 130 (1981).

Perhaps most importantly, *Metropolitan Life* addressed the vitality of a state law which by its very nature was more likely to have widespread and profound impact upon self-funded employee welfare benefit plan than the Pennsylvania anti-subrogation statute. The Massachusetts statute directed insurers to offer minimum level mental health coverage in any policy sold within that Commonwealth. *Metropolitan Life*, 471 U.S. at 731. The law was enforced against Metropolitan and the Travelers Insurance Company through a state court proceeding which sought a permanent injunction against the continued sale of policies which did not conform to the state law. *Id.*, at 734. Enforcement of the Massachusetts law against the fiduciary of a self-funded plan places the fiduciary at risk of liability for any remedies granted the state under the mandatory benefits law, including civil fines and possible imprisonment in the event a state court determines that the fiduciary has violated an injunctive order. One may conceive that Congress intended to prevent plan fiduciaries from this type of risk.

The Pennsylvania anti-subrogation law is entirely different in character. It provides for no affirmative remedy against any plan fiduciary. It imposes no obligation upon any plan, and does not require the plan to take any action whatsoever. It imposes upon the plan fiduciary no

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<sup>19</sup> In view of Massachusetts failure to enforce its mandated benefits laws against self-funded plans, Petitioner's characterization of this language as part of the Court's holding (Brief of Petitioner, at 15-16.) is undoubtedly wrong.

ongoing obligation to pay benefits, process particular types of claims, or maintain additional records. It simply provides that the plan has no greater rights than an insurance company to attempt to enforce, by contractual clause or otherwise, a traditional state remedy which had been abolished as part of a comprehensive automobile insurance regulatory scheme.

Several later decisions of this Court support the distinction between mandated benefits and anti-subrogation laws. In *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41 (1987) this Court found that a state cause of action for contractual bad faith was not saved by §514(b)(1), and consequently did not address the scope of the "deemer" clause.<sup>20</sup> Noting that "the purpose of Congress is the ultimate touchstone," 481 U.S. 41, 45, the Court looked beyond the *Metropolitan Life* decision to examine "the role of the saving clause in ERISA as a whole." *Id.* at 51. The opinion cites to the civil enforcement provisions of ERISA, finding that "the policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id.* at 54. *Pilot Life* cannot, therefore, be cited for the proposition that Congress intended to preempt anti-subrogation laws when it enacted §514, as the state law challenged there created the affirmative burden of administration and risk of recovery against plans which Congress intended to forbid.

Two later decisions of this Court reject the sweeping proposition posed by Petitioner that self-funded plans are free from the effects of all state laws. In *Fort Halifax Packing Company, Inc. v. Coyne*, 482 U.S. 1 (1987) the Court determined that a Maine statute requiring a one-time severance payment to employees upon plant closure was

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<sup>20</sup> See 481 U.S. at 51.

not preempted by ERISA. In so holding, the Court announced:

" . . . in effect, Appellant argues that ERISA forecloses all state legislation regarding employee benefits. This contention fails, however, in light of the plain language of ERISA's preemption provision, the underlying purpose of that provision, and the overall objectives of ERISA itself." 482 U.S. at 7.

The Court found the Maine statute to survive §514 because it neither mandated the creation of a plan nor imposed ongoing administrative demands on an existing plan. *Id.* at 12-14.

Of equal importance was the Court's concern with the statute's failure "to implicate the regulatory concerns of ERISA itself." *Id.* at 15. The Court noted that "the focus of the statute thus is on the administrative integrity of benefit plans . . ." and found in both 29 U.S.C. §1001 and portions of legislative history that Congressional policy with respect to the fiscal integrity of plans was aimed, not at allowing plans to collect monies in any manner deemed appropriate by their fiduciaries, but rather to protect the participants from mis-mal- or non-feasance by fiduciaries. *Id.* at 15.

The Court had the opportunity to focus its attentions directly upon a traditional state law function in *Mackey v. Lanier Collections Agency and Services, Inc.*, 486 U.S. 825 (1988). At issue were Georgia's regulations concerning collection of money judgments. One of these exempted ERISA plans from garnishment proceedings. This Court struck down the protective act, holding that the statute (which expressly referred to ERISA plans) obviously "related to" such a plan and did not come within any of the exceptions contained in §514(b). But this Court went on to reject a contention that Georgia's general garnishment statute was preempted when applied to ERISA plans. Noting that "it is the intent of the Congress that enacted (the Section) . . . that controls", citing *Teamsters v. United States*, 431 U.S. 324, 354, N. 39 (1977), the Court

examined the "sue or be sued" provisions of ERISA and concluded that Congress intended ERISA plans to be subject to state garnishment laws. In so doing, the Court acknowledged that "lawsuits against ERISA plans for run-of-the-mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan - are relatively commonplace", 486 U.S. at 833, and cited the concession of the Petitioners and the Solicitor General that such suits "although obviously affecting and involving ERISA plans and their trustees, are not preempted by ERISA §514(a)". The Court refused to find preemption, despite the Petitioner's apparently undisputed contention that increased administrative burden and cost would result from plan susceptibility to state law garnishment proceedings. 486 U.S. at 831. *Mackey* thus demonstrates that preemption under §514(a) requires more than an assertion or finding of administrative inconvenience or cost to a plan.

The thrust of the foregoing analysis is that this Court has routinely and uniformly examined the Congressional intent and policy behind the preemption provisions of ERISA. At no time has this Court ever adopted a so-called "bright line" test for any portion of §514. No holding of this Court has ever determined that it was Congressional policy to eradicate state automobile insurance or subrogation laws as applied to self-funded employee welfare benefit plans. The lower court's reference to "core concerns" of ERISA, while perhaps not artfully framed, is nothing more than an effort to ferret out Congressional intent regarding the scope of §514. The lower court followed the procedures established by this court for statutory interpretation, and rendered a decision consistent with the prior holdings of this Court.<sup>21</sup>

<sup>21</sup> Petitioner contends that the lower court's opinion in this case "is inconsistent with the weight of appellate authority". Brief of Petitioner, pages 16-17. As previously noted by Respondent, however, most of the cases cited by Petitioner

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## II. REVERSAL OF THE LOWER COURT'S DECISION WILL NOT FURTHER THE AIMS OF ERISA.

As there is no statutory language or legislative history addressing the effect of the "deemer" clause upon either self-funded employee welfare benefit plans or state anti-subrogation statutes, there is no express Congressional purpose or policy upon which reversal of the lower court's judgment may be based. Petitioner and the Solicitor General thus point to various broad ERISA policies which they claim to be violated by the Pennsylvania statute. A close examination of Petitioner's position reveals, however, that these policies do not act to support preemption here.

Petitioner's first concern is that the lower court's ruling violates the Congressional policy in favor of national uniformity of plan administration, citing *inter alia* its own experience in the subrogation field. Undoubtedly, Congress intended regulation of essential day-to-day plan business of employee welfare benefit plans to be left exclusively to the federal government, so as to guarantee that the benefits of uniformity in ongoing administrative practices would accrue to plans. However, neither Congress nor this Court has ever declared that ERISA was intended to establish self-funded plans as a law unto themselves. As this Court recognized in *Metropolitan Life*:

"We are also aware that Appellant's construction of the statute would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the Congressional decision to 'save' local insurance regulation. Arguments

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have little or nothing to do with the question of state anti-subrogation laws as applied to self-funded benefit plans. See Respondent's Brief in Opposition to Petition for Writ of Certiorari, pages 8-10.

as to the wisdom of these policy choices must be directed at Congress." 471 U.S. at 747,

Nothing in the statute or legislative history reveals why self-funded plans should be spared all disuniformity while insured plans are not, particularly since Congress defined "employee welfare benefit plan" to include all such plans, whether funded by insurance or not. 29 U.S.C. §1002(1)<sup>22</sup> The issue to be addressed by this Court is not interstate disuniformity of plan administration, *per se*, but rather the types of interstate disuniformity of plan administration which Congress sought to prevent.

Moreover, subrogation is not the sort of matter with which Congress appeared to be concerned in enacting Section 514. Congressional concern appeared to center around the avoidance of duplicative record keeping and day-to-day, alternative paper requirements which might be imposed by conflicting state and local regulations. See *Fort Halifax Packing Co.*, 482 U.S. at 12-15. An anti-subrogation law imposes no administrative burden upon a plan fiduciary, and does not raise the spectre of state audits of plan documents or state court actions challenging fiduciary conduct.

Petitioner's concerns regarding disuniformity are further diluted when one considers that many self-funded plans are administered by insurance companies which provide administrative services for a fee. See, e.g. Brief of the Travellers Insurance Company as Amicus Curiae in support of Petitioner, pages 1-2. Indeed, at the time Respondent's father applied for benefits, Petitioner utilized the Equitable Life Assurance Society of the United States as its Claim Administrator. Joint Appendix,

<sup>22</sup> If disuniformity is to be avoided at all costs, the outcome in *Mackey* would have been quite different. Interstate plans are susceptible to suit in certain states on certain causes of action which might not exist in other states. Such plans will also have to be administered with an eye towards each state's procedural requirements (e.g. garnishment), which differ from state to state.



page 120. Plans such as Petitioner can hardly complain of the difficulties of interstate plan administration where, as noted by the Solicitor General, "the insurance company that sold the policy - which should be accustomed to inconsistent regulation in light of the long tradition of state primacy in the area of insurance regulation - would presumably assist the purchaser in adjusting to the different rules of the various states." Brief of the Solicitor General, pages 27-28, N. 25.

Petitioner's next concern is reduction of litigation through adoption of a bright-line test. This Court has previously recognized that the structure of §514 necessarily invites litigation. See, e.g., *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. at 47. Given the ambiguities of Section 514, it is doubtful that reversal of the lower court here will prevent any substantial amount of future litigation over the meaning of the "deemer" clause in areas other than the narrow one presented in this case, i.e., the application of anti-subrogation insurance laws to self-funded plans. Further, since a federal common law of ERISA rights and obligations is to be expected, see *Pilot Life*, 481 U.S. at 55-56, self-funded plans may be expected to appear in the federal courts repeatedly over the years. The degree to which adoption of Petitioner's position will result in reduced litigation is a matter of pure speculation.<sup>23</sup>

Petitioner next frets over the increased cost to plans by state laws avoiding subrogation rights. The record is, of course, devoid of any evidence as to the degree to which anti-subrogation insurance laws impinge upon the fiscal soundness of self-funded plans, or of the degree to which the benefits to be offered to participants will be trimmed as a direct result of the unavailability of

<sup>23</sup> Indeed, a sound argument exists to suggest that sustaining Petitioner's position will result in increased litigation. See Brief for the National Conference of State Legislatures et al., as Amicus Curiae in Support of Respondent, pages 26-27.

subrogation.<sup>24</sup> Naturally, Petitioner's cost argument presupposes that Congress intended every state law which could conceivably cost a plan money to be preempted. The *Mackey* Court rejected this notion, and nothing in the

<sup>24</sup> The Brief of The National Coordinating Committee for Multiemployer Plans as Amicus Curiae in Support of Petitioner, cites the limited experience (and future expectations) of one plan and a 1984 study indicating that one to two percent of all medical claims can be recouped through a "vigorous subrogation program" Id., page 20, note 16. This "study" consists of citation to four cases (including one in which the amount of gross recovery is undisclosed), and the early experience of an unidentified "Fortune 50" corporation in twenty-two cases, at least nineteen of which were *expected* (rather than *actual*) subrogation recoveries. It is the experience of this Fortune 50 company upon which the one to two percent figure is based.

One cannot tell from the original article whether these were gross recoveries or net amounts received by the subrogor after the claims administrators and attorneys had been paid. In any event, while subrogation would concededly result in some financial benefit to self-funded plans, these nuggets are an insufficient basis for adoption of the sweeping policy demanded by Petitioner.

The article cited by Amicus goes on to note that many insurance carriers do not find subrogation worth the trouble. Wille, *Subrogation/Third Party Reimbursement: An Overlooked Way to Reduce Health Benefit Costs*, 1 Health Cost Management No. 9, at 4 (June, 1984). While the author attributes this phenomenon to insurer sloth, an alternative explanation may be a market-tested experience that subrogation is not as cost-effective as Petitioners would have the Court believe.

Finally, Petitioner overlooks the fact that only subrogation in motor vehicle cases has been abolished in Pennsylvania. Petitioner retains its full subrogation rights in other sorts of litigation, such as products liability, medical malpractice, and premises cases. No authority is cited to indicate that anti-subrogation laws are (or will become) prevalent in these areas.

legislative history or the statute itself is cited to support so broad a reading of Congressional intent.<sup>25</sup>

Finally, Petitioner almost incredibly suggests that precluding subrogation by self-funded plans against participant's tort recoveries will thwart congressional intent "without returning any real benefits to plan participants." Brief of Petitioner, page 30. The obvious benefit to the participant is prompt payment of medical benefits coupled with more prompt resolution of his/her tort claim, due to the absence of a complicating factor: a subrogor-plan. Obviously, the presence of a subrogor-plan complicates the tort settlement process, as each dollar not received by the participant must be recouped via a higher settlement demand, in turn creating greater resistance to settlement by the tortfeasor and/or his liability carrier. Greater difficulty in settlement naturally translates into more trials and cases in which defense verdicts remove any monetary recovery from the hands of the participant (and, consequently, the subrogor-plan).

Alternatively, as has occurred with Respondent, a participant's injuries may be so grave and the sources of liability insurance recovery so limited that a subrogation lien will assure that the participant will not receive a fair measure of recovery. Several of the Amicus Briefs decry the "double recovery" which they assume many plan participants to have received. Of course, there is no statistical data to support the notion that double recovery is

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<sup>25</sup> Various of the Amicus Briefs point to the burgeoning cost of health care as a justification for maintenance of subrogation rights in self-funded plans. Obviously, health care cost containment is a national concern, affecting both plans and participants alike. It remains a mystery as to how anti-subrogation laws have caused this phenomenon, or why a holding in favor of Petitioner would stem the tide. Respondent suggests that health care costs are better managed by comprehensive Congressional action, rather than by incremental invasions into traditional areas of state regulation under a federal statute not designed to address the particular problem.

pervasive. In the instant case, for example, Petitioner is a teenage girl who suffered a severe brain injury as a result of her depressed skull fracture. She will net less than \$50,000.00 from her tort action against the negligent driver. While it is unclear how much of her medical bills will have to be paid out of her recovery, she has suffered damages for impairment of earning capacity, pain, suffering and inconvenience far in excess of what she will ever recover, even if this Court finds in her favor. (J.A. 84-85).

A related difficulty with Respondent's position arises from the likely damage to the states' motor vehicle claims processes resulting from the adoption of Petitioner's position. This Court has previously expressed its sensitivity to maintenance of the states' tort systems in the face of federal preemption. *San Diego Building Trades Council v. Garman*, 359 U.S. 236, 248 (1959). Pennsylvania has recently abolished the so-called "collateral source" rule with respect to motor vehicle accident claims,<sup>26</sup> thus prohibiting double recoveries for medical expenses. However, this provision is part-and-parcel of a comprehensive automobile insurance program which includes the anti-subrogation statute challenged now. If Petitioner's fears are correct, plan participants who do not have sufficient medical coverage under their automobile insurance policy will look to their self-funded plans for payment of

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<sup>26</sup> "Preclusion of recovering required benefits. In any action for damages against a tortfeasor, or in any uninsured or underinsured motorist proceeding, arising out of the maintenance or use of a motor vehicle, a person who is eligible to recover benefits under the coverages set forth in this subchapter, or Worker's Compensation, or any program, group contract or other arrangement for payment of benefits as defined in Section 1719 (related to coordination of benefits) shall be precluded from recovering the amount of benefits paid or payable under this subchapter or Worker's Compensation or any program, group contract or other arrangement for payment of benefits as defined in Section 1719". 42 Pa.C.S.A. Section 1722, effective July 1, 1990.

medical bills. The amounts paid by the plans will not be recoverable in any tort action, as Section 1722 is a *per se* bar to such recoveries.<sup>27</sup> Plans will, in Petitioner's world, be permitted to subrogate against recoveries or settlements which cannot include dollars attributable to the expenses covered by the plans. Thus, plan participants doubtless will have grossly inadequate (rather than double) recoveries for injuries sustained in motor vehicle accidents. This will be a national phenomenon, given the widespread use of anti-subrogation laws in no-fault states. See *Wille, op. cit.*, pages 3-4.

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### CONCLUSION

For the foregoing reason, the Respondent prays this Court to affirm the judgment of the Third Circuit Court of Appeals.

Respectfully submitted,

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<sup>27</sup> Petitioner has not challenged in this Court the finding that the FMC plan is a "program, group contract or other arrangement for payment of benefits" as defined in the anti-subrogation statute. This portion of Section 1722 is identical to Section 1720 in this vein.



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No. 89-1048

Supreme Court, U.S.

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In The  
**Supreme Court of the United States**  
October Term, 1989

—◆—  
FMC CORPORATION,

*Petitioner,*

vs.

CYNTHIA ANN HOLLIDAY,

*Respondent.*

—◆—  
On Writ Of Certiorari To The United States  
Court Of Appeals For The Third Circuit

—◆—  
REPLY BRIEF FOR PETITIONER

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## REPLY BRIEF OF PETITIONER

### I. Neither The Plain Language Of The Deemer Clause Nor Its Legislative History Support The Alternative Constructions Urged By The Respondent And The Amici.

The "ultimate touchstone" of every preemption question is congressional intent. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987). Thus, in this case of express preemption, the inquiry must "begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985) (quoting *Park N' Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985)) (emphasis added). Despite explicitly and implicitly conceding that FMC's reading of the deemer clause is completely in accord with the statutory language,<sup>1</sup> Respondent and the amici nonetheless argue that the deemer clause does not mean what it says. Their analysis ignores parts of the

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<sup>1</sup> See Respondent Brief at 9 ("Petitioner and the Solicitor General narrow their arguments to focus upon the 'deemer clause' itself."); Brief of the American Chiropractic Association at 14 ("[T]he language used by Congress in the deemer clause may appear to prevent the application of every state insurance law to every employee benefit plan. . . ."). See also Brief of Amici Curiae National Conference of State Legislatures, et al. at 11 n. 23, submitted in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (Nos. 84-325 and 84-356) ("This 'deemer' clause simply prohibits the state from regulating employee welfare plans by calling them insurers. It does not prohibit the state from regulating bona fide insurers when they are doing business with employee benefit plans.").

language of the deemer clause, misinterprets the fragments of the statute and ERISA's legislative history upon which they focus<sup>2</sup> and fails to suggest a clear and rational alternative rule of decision which will resolve deemer clause issues. Thus, this Court should reject the alternative constructions of the deemer clause offered by the Respondent and the *amici* and interpret the clause as drafted by Congress: to prevent application of state insurance laws to self-funded employee benefit plans.

**A. The Plain Language Of The Deemer Clause Does Not Support Any Of The Alternative Constructions Suggested By The Respondent.**

The plain language of the deemer clause prohibits states from treating employee benefit plans as if they were "an insurance company or other insurer . . . or engaged in the business of insurance . . . for the purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts. . . ." 29 U.S.C. §1144(b)(2)(B) (emphasis added). Respondent and the *amici* concede that Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law of 1984 (the "Financial Responsibility Law"), 75 Pa. Cons. Stat. Ann. §1720 (Purdon 1984), treats FMC's self-funded benefit

<sup>2</sup> Because the statutory language unambiguously preempts Section 1720 of the Financial Responsibility Law, this search for congressional intent in ERISA's legislative history is unnecessary. See *infra* pp. 7-8.

plan as if it were engaged in the business of insurance.<sup>3</sup> Thus, the correct result under ERISA's express preemption provisions and *Metropolitan Life* is that Section 1720 is preempted from application to self-funded benefit plans. In their effort to avoid this result, Respondent and *amici* stray from the statute's plain language in search of vague "alternative" constructions of the deemer clause. None of the alternatives presented is grounded in ERISA's statutory language, its legislative history or in this Court's precedent.

FMC's initial brief on the merits detailed the reasons why two of the alternative constructions suggested by the Respondent, those set forth by the court below and by the Sixth Circuit in *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988), are incorrect. See Petitioner Brief at 10-27.<sup>4</sup> Thus, this brief will focus primarily on the third,

<sup>3</sup> *Amici*, the National Conference of State Legislatures, *et al.* (hereinafter the "NCSL"), argue simply that Section 1720 of the Financial Responsibility Law is not among the laws that Congress meant to preempt by the deemer clause. The NCSL, like Respondent, concedes that Section 1720 treats the Health Plan in exactly the same way in which it regulates all other insurance arrangements.

<sup>4</sup> The Third and Sixth Circuits ground their holdings in the statutory language *only* by focusing narrowly on Congress' use of the word "purporting." See *FMC v. Holliday*, 885 F.2d 79, 86-87 (3d Cir. 1989), *cert. granted*, 110 S.Ct. 1109 (1990); *Northern Group Services*, 833 F.2d at 93 n.3. The NCSL expressly disavows this approach. See NCSL Brief at 15 n. 8 ("[W]e would not put the inquiry in terms of 'pretext.'"). It also appears that the Third Circuit has disavowed its own construction of the deemer clause by affirming a decision that adopted FMC's position. See *Drexelbrook Engineering Co. v. Travelers Ins. Co.*, 710 F. Supp. 590 (E.D. Pa.), *aff'd without opinion*, 891 F.2d 280 (3d Cir. 1989).

and most recent, construction to arise in this case, *i.e.*, the deemer clause should be construed to allow states to apply to self-funded plans any insurance law not intended to regulate "insurance as a business." See Respondent Brief at 8; NCSL Brief at 7, 12-16.

This narrow construction of the deemer clause is unacceptable for a variety of reasons. First, as Respondent aptly notes, "when expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." See Respondent Brief at 9-10 (quoting *Pilot Life Ins.*, 481 U.S. at 51 (1987) (citations omitted)). The Respondent and the NCSL, however, violate this fundamental canon of statutory construction.

Indeed, the NCSL reaches its construction of the deemer clause only by focusing on a fragment of the deemer clause, the phrase "business of insurance." See NCSL Brief at 14-15. It conveniently omits from its analysis that portion of the deemer clause prohibiting states from applying to self-funded plans laws "purporting to regulate insurance companies [or] *insurance contracts*." 29 U.S.C. § 1144(b)(2)(B). Because Section 1720 of the Financial Responsibility Law regulates the terms of insurance contracts, *see FMC*, 885 F.2d at 86, it is certainly within the reach of the deemer clause.

The NCSL then strays further from fundamental methods of statutory construction by construing the deemer clause without reference to the saving clause.<sup>5</sup> In

<sup>5</sup> As this Court has stated, the deemer clause modifies the saving clause. *Metropolitan Life*, 471 U.S. at 741.

*Metropolitan Life*, this Court looked to the deemer clause for guidance in interpreting the saving clause and found the reference to insurance contracts particularly enlightening:

By exempting from the saving clause *laws regulating insurance contracts that apply directly to benefit plans*, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause. Unless Congress intended to include *laws regulating insurance contracts* within the scope of the insurance saving clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans.

471 U.S. at 741 (emphasis added). Thus, when construed in accordance with the plain language of the statute and the teaching of *Metropolitan Life*, the deemer clause prohibits states from applying directly to self-funded plans laws that regulate insurance contracts.

The second flaw in the NCSL's argument is that its apparent definition of "business of insurance" is completely at odds with this Court's well-established definition of that phrase.<sup>6</sup> This Court has long held that when Congress uses the phrase "business of insurance," it is

<sup>6</sup> The NCSL never actually defines the phrase "business of insurance," preferring instead to give examples of those state laws which relate to the business of insurance. *See, e.g.*, NCSL Brief at 2 (laws "involving licensing and capitalization of insurance companies") and 14 (laws "directed at the creation, management and structure of insurers").



focusing on the relationship between the insurer and his insured:

The relationship between the insurer and the insured, *the type of policy which could be issued*, its reliability, its interpretation, and enforcement – these were the core of the “business of insurance.” . . . Statutes aimed at protecting or regulating [the insured – insurer] relationship, directly or indirectly, are laws regulating the “business of insurance.”

*Metropolitan Life*, 471 U.S. at 744 (quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)) (emphasis in original). Significantly, when it appeared as *amicus curiae* in *Metropolitan Life*, the NCSL was in complete agreement with the definition of “business of insurance,” as set forth in *National Securities*. See Brief of Amici Curiae National Conference of State Legislatures *et al.* at 14-15, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (Nos. 84-325 and 84-356). As the NCSL recognized in 1985, when Congress uses the phrase “business of insurance,” it simply does not distinguish between those laws regulating “insurance as a business” and those laws regulating the insured – insurer relationship. Thus, the NCSL may not now inject such a distinction into the deemer clause.

Moreover, this Court in *Metropolitan Life* rejected a distinction between “traditional” insurance laws and “innovative” insurance laws, see *Metropolitan Life*, 471 U.S. at 741, that is analogous to the NCSL’s distinction between laws regulating the business of insurance and the insurer – insured relationship. See NCSL Brief at 14. This Court in *Metropolitan Life* found the traditional –

innovative dichotomy “unpersuasive” because: (1) neither the saving clause nor the deemer clause make such a distinction; (2) the legislative history does not support it; and (3) such a construction violates the plain meaning of the statutory language. *Id.* at 741-42. For those same reasons, the construction of the deemer clause advocated by the NCSL must fail.

Finally, Respondent and NCSL suggest that the deemer clause is not meant to preclude the application of state insurance laws directly to plans because the clause does not, on its face, make a distinction between insured and self-insured plans. See Respondent Brief at 9; NCSL Brief at 20. This position is disingenuous and flatly wrong. As the *Metropolitan Life* Court determined, the distinction between insured and self-funded plans is the result of the interaction between the saving and deemer clauses. 471 U.S. at 747.<sup>7</sup> FMC’s construction of the deemer clause observes this distinction, in keeping with both the statutory language and *Metropolitan Life*.

#### **B. The Legislative History Does Not Support The Alternative Constructions Urged By Respondent.**

“When a federal statute unambiguously precludes certain types of state legislation, [this Court] need go no further than the statutory language to determine whether

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<sup>7</sup> Despite chiding FMC for its reliance on *Metropolitan Life*, Respondent concedes, as it must, that no decision is more important to this case since, in *Metropolitan Life*, this Court had the opportunity to review the interaction of the saving and deemer clauses. Respondent Brief at 16.

the state statute is preempted." *Exxon Corp. v. Hunt*, 475 U.S. 355, 362 (1986) (citing *Aloha Airlines, Inc. v. Director of Taxation*, 464 U.S. 7, 12 (1983)). In this express preemption case, the wide ranging search by Respondent and the *amici* for congressional intent is inappropriate. See *Aloha Airlines*, 464 U.S. at 12 n.5 (noting that such a search for congressional intent is only appropriate in cases of implied preemption). Additionally, the legislative history is not particularly enlightening on the precise issue presented here, because there is little, if any, legislative history directly relevant to the relationship between the saving and deemer clauses. See *Metropolitan Life*, 471 U.S. at 745.<sup>8</sup> Nevertheless, the NCSL contends that the legislative history *requires* a construction of the deemer clause that allows states to regulate the terms of self-funded benefit plans, a position that is flawed for three basic reasons.

First, the NCSL argues that since the language of the deemer clause remained unchanged while the broad preemption provision, Section 514(a), was expanded, one *must* infer that the deemer clause was relegated to performing the more narrow, specified work designated for the original preemption clause. See NCSL Brief at 12. This

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<sup>8</sup> The Respondent mischaracterizes FMC's use of the legislative history. See Respondent Brief at 12. FMC relied on the legislative history of ERISA only to confirm that the results flowing from its construction of the deemer clause are in accord with generally expressed congressional intent. See Petitioner Brief at 27-32.

argument is illogical and betrays NCSL's fundamental misunderstanding of the interworkings of ERISA's preemption provisions. The deemer clause modifies the saving clause, not Section 514(a). See *Metropolitan Life*, 471 U.S. at 741. Accordingly, the fact that Congress broadened Section 514(a) says nothing about the relationship between the saving and deemer clauses.<sup>9</sup> To conclude otherwise is to defy logic.

Second, in the absence of legislative history supporting its position, the NCSL must contrive a "hypothetical" legislative intent. See NCSL Brief at 12-15. The NCSL first creates a "specific and limited problem" which pre-ERISA self-funded benefit plans purportedly faced, namely, the possibility that states would drive them out of business by regulating them as commercial insurers. *Id.* Significantly, the legislative history makes no reference to the specific problem identified by the NCSL. The legislative silence reveals that the NCSL is engaged in speculation as to whether this problem actually existed, whether it had any effect on congressional intent and whether this problem, if it was considered by Congress, led to the passage of the deemer clause.

Finally, in dismissing the legislative history regarding the breadth of ERISA preemption as not helpful and "simply beside the point," see Respondent Brief at 12, 17; NCSL Brief at 17, Respondent and *amici* ignore the only clear congressional intent regarding the scope of ERISA

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<sup>9</sup> Of course, the fact that Congress broadened Section 514(a) does demonstrate that Congress sought to establish clearly that regulation of benefit plans was to be exclusively a federal concern.

preemption. By broadening the scope of Section 514(a), Congress evinced an unmistakable intent to make employee benefit plan regulation exclusively a federal matter. Yet, under any of the three alternative approaches advocated by Respondent, the scope of ERISA preemption would be narrowed, with the result that states could effectively govern the content and interpretation of benefit plans under the guise of their insurance, banking and securities laws.<sup>10</sup> Surely, Congress did not intend such a result.<sup>11</sup>

## II. Preemption of State Insurance Law As Applied To Self-Funded Plans Furthers The Purposes of ERISA And Does Not Create The Problems Suggested By Respondent And The *Amici*.

Respondent and the *amici* cavalierly brush aside the difficulties that Congress intended to remedy by broad

<sup>10</sup> For example, the mandated benefit laws at issue in *Metropolitan Life* would presumably be applicable to self-funded plans under any of the Respondent's alternative constructions of the deemer clause.

<sup>11</sup> The final piece of legislative history relied upon by the NCSL does not support its narrow construction of the deemer clause. See NCSL Brief at 18 (discussing comments of Representative Dent). Representative Dent's reference to the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e-10, is not particularly instructive as to the intended meaning of the deemer clause. The preemption provisions of the HMO Act and ERISA are drastically different, so it is difficult to discern exactly what Representative Dent meant by his vague reference to the HMO Act. If any lesson is to be taken from the comparison of ERISA to the HMO Act, that lesson should be that Congress could specifically limit preemption of state insurance laws to those governing capitalization of insurance companies when that was, in fact, the result it desired. Compare 42 U.S.C. § 300e-10 with 29 U.S.C. § 1144.

preemption. At the same time, they predict that dire consequences would flow from construction of the deemer clause as enacted. None of their contentions, however, warrant deviation from the plain language of the deemer clause.

### A. Congress Sought Uniform Federal Regulation of ERISA Benefit Plans.

This Court has recognized consistently that Congress was concerned that the burden of multiple and conflicting state regulation would discourage employers from establishing plans and would make plan administration difficult. See, e.g., *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 n.25 (1983). All of Respondent's alternative constructions of the deemer clause, however, allow states to regulate pervasively self-funded plans under the guise of their insurance law and thus would result in multiple state regulations being applied to single employee benefit plans. This plainly violates congressional intent.

Respondent and *amici* attempt to minimize this fact by fixing the Court's focus on the admitted disuniformities faced by multistate *insured* plans, the state-law disuniformities between insured and self-funded plans and any disuniformities which may ultimately result from "hybrid" plans.<sup>12</sup> However, this misses the point.

<sup>12</sup> "Hybrid" plans are those self-funded plans that hire an insurance company to administer the plan or those plans that are self-funded to a certain level of risk with insurance covering the excess. Despite the NCSL's contention that "hybrid"

(Continued on following page)



These disuniformities "are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life*, 471 U.S. at 747. Respondent and amici, by urging the adoption of one of their alternative constructions, would have this Court choose the disuniformities resulting from multiple state regulation of a single self-funded plan over the disuniformities which exist between insured and self-funded plans. Congress, however, chose the latter, and arguments over the wisdom of that choice must be directed there. *Ibid.*

Finally, The Pennsylvania Trial Lawyers Association asserts that, by the terms of the Health Plan, FMC invited some disuniformity when it "invoked" Pennsylvania's coordination of benefits law with respect to benefits provided by Mr. Holliday's no-fault motor vehicle insurance. See Trial Lawyers Brief at 17-20. This position is nonsensical. Although the Health Plan contains a coordination of benefits provision that *always* requires plan participants to resort first to their no-fault auto insurance, see J.A. 62-63 ("In the case of coverage by 'no-fault' automobile insurance, FMC will pay covered expenses not paid for by no-fault insurance."), it does not follow that FMC thereby invoked Pennsylvania's coordination of

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plans pose certain difficulties under FMC's construction of the deemer clause, see NCSL Brief at 23, courts have been dealing ably with those questions. See, e.g., *Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987); *Drexelbrook Engineering Co. v. Travelers Ins. Co.*, 710 F. Supp. 590 (E.D.Pa.) (collecting cases and holding that plan which purchased stop-loss coverage was self-funded for purposes of ERISA preemption), *aff'd without opinion*, 891 F.2d 280 (3d Cir. 1989).

benefits law.<sup>13</sup> Even if this were the case, this point is irrelevant to the appropriate construction of the language of the deemer clause and the intent of Congress.

#### B. Congress Intended ERISA To Protect Plan Participants.

Contrary to the NCSL's contention, NCSL Brief at 22, construction of the deemer clause in accordance with its plain language benefits plan participants. When it enacted ERISA, Congress chose not to regulate the substantive content of welfare-benefit plans, see *Metropolitan Life*, 471 U.S. at 732, but that does not mean that preemption of state insurance regulation as applied to self-funded plans creates a harmful "regulatory vacuum." See NCSL Brief at 22 (Preemption of state insurance law as applied to self-funded plans will "sweep away the protections of state insurance and health policy as well."). Simply put, the NCSL's "regulatory vacuum" argument is at odds with the protections that ERISA itself provides to benefit plan participants and is also inconsistent with the decisions of this Court.<sup>14</sup>

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<sup>13</sup> Pennsylvania makes the no-fault carrier the primary insurer for injuries sustained in auto accidents. 75 Pa. Cons. Stat. Ann. § 1719 (Purdon 1984).

<sup>14</sup> ERISA protects plan participants by "elaborate" reporting, disclosure and fiduciary requirements. See *Massachusetts v. Morash*, 109 S.Ct. 1668, 1671-72 (1989). Additionally, broad preemption itself protects plan participants. See Staff of Senate Comm. on Labor and Public Welfare, 94th Cong. 2d Sess., *reprinted in* Legislative History of ERISA 4670 (Comm. Print 1976) (statement of U.S. Rep. John Dent) ("With the preemption

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Moreover, the NCSL's "regulatory vacuum" argument proves too much. State laws providing an extra layer of "protection" to participants are not safe from preemption, even when those laws do not conflict with ERISA. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (holding that ERISA preempts state anti-discrimination statute). See also *Mackey v. Lanier Collections Agency & Service, Inc.*, 486 U.S. 825, 830 (1988) ("Legislative 'good intentions' do not save a state law within the broad preemptive scope of Section 514(a).").

Finally, the NCSL's "regulatory vacuum" argument assumes that protection of plans and protection of plan participants are mutually exclusive. They are not. Establishment of benefit plans by employers is voluntary. See *Shaw*, 463 U.S. at 90. Congress sought to encourage the establishment of plans by making regulation of plans exclusively a federal matter. See *Fort Halifax*, 482 U.S. at 11. This statutory scheme thus inures to the ultimate benefit of plan participants by spurring the creation of plans where they might not otherwise exist. The Respondent's alternative constructions of the deemer clause will undermine this congressional goal to the detriment of current and prospective plan participants.

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(Continued from previous page)

of the field, we round out the *protection afforded participants* by eliminating the threat of conflicting and inconsistent state and local regulation." (emphasis added). Plan participants may also take enforcement action against plan administrators with the conduct of those fiduciaries subject to *de novo* review by the courts where a plan does not give an administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan. See *Firestone Tire and Rubber Co. v. Bruch*, 109 S.Ct. 948, 956 (1989).

### C. The Limitations Of ERISA Preemption Will Prevent The Abrogation Of State Law Predicted By The Respondent.

Respondent and the *amici* mischaracterize the ultimate effects of prohibiting states from imposing their insurance regulation on self-funded plans. They contend that allowing the deemer clause to prohibit state regulation of self-funded benefit plans will allow plans to make their own rules with drastic effects on state tort laws. See Respondent Brief at 27. This will simply not be the case.

State laws are preempted if they "relate to" employee benefit plans. See *Pilot Life*, 481 U.S. at 47. But, ERISA preemption is subject to some limitation because "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. Therefore, plan administrators will be unable to "write any procedural or evidentiary rule into its plan and seek to enforce it against non-beneficiaries," see Trial Lawyers Brief at 23, because the state laws that overreaching plan administrators might hope that ERISA would preempt would generally not relate to benefit plans. See, e.g., *Mackey v. Lanier Collections Agency & Service, Inc.*, 486 U.S. 825 (1988) (Georgia's general garnishment statute does not relate to ERISA benefit plans.).

However, despite the NCSL's contention to the contrary, see NCSL Brief at 5-6 n.2, the limits of ERISA preemption are not tested in this case. Section 1720 of the Financial Responsibility Law does relate to ERISA benefit plans. "A law 'relates to' an employee benefit plan . . . if it has a connection with or reference to such a plan."

*Shaw*, 463 U.S. at 96-97. Section 1720 has a direct effect on the relationship between the Health Plan and its participants. Furthermore, it singles out insurance arrangements, specifically including employee benefit plans, and takes away their contractual and common law subrogation rights. Thus, Section 1720 certainly "relates to" the Health Plan. See *Shaw*, 463 U.S. at 108 (Anti-discrimination statute which structures relation between participant and plan preempted.). Cf. *Mackey*, 486 U.S. at 830 (Anti-garnishment statute which expressly singles out ERISA plan for special treatment relates to benefit plan.). Accordingly, construction of Section 514 of ERISA to prevent application of Section 1720 to the Health Plan is appropriate, and such a result will not lead to the problems predicted by Respondent and *amici*.

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### CONCLUSION

Construction of the deemer clause will affect the states' authority to regulate self-funded plans in areas far beyond subrogation. Accordingly, a clear delineation of the boundary between the saving and deemer clauses is necessary to guide states and plans in their everyday operation. The holding of *Metropolitan Life* defined that boundary in a manner that comports both with the statutory language and congressional intent. None of the alternatives urged by the Respondent suggest a rule of decision that is faithful to the statutory language or provides for ease of application to other situations. Perhaps even more importantly, each of the alternatives allows states to regulate pervasively the terms of self-funded benefit plans. This undesirable and unacceptable result

should be avoided by reaffirming *Metropolitan Life* and adhering to the plain language of the deemer clause.

Respectfully submitted,

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**In the Supreme Court of the United States**

OCTOBER TERM, 1989

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**FMC CORPORATION, PETITIONER**

*v.*

**CYNTHIA ANN HOLLIDAY**

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**ON WRIT OF CERTIORARI TO THE  
UNITED STATES COURT OF APPEALS  
FOR THE THIRD CIRCUIT**

---

**BRIEF FOR THE UNITED STATES  
AS AMICUS CURIAE SUPPORTING PETITIONER**

---

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### **QUESTION PRESENTED**

Whether Section 514 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144, pre-empts the application of state insurance laws to uninsured employee benefit plans.

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**In the Supreme Court of the United States**

OCTOBER TERM, 1989

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No. 89-1048

FMC CORPORATION, PETITIONER

*v.*

CYNTHIA ANN HOLLIDAY

---

*ON WRIT OF CERTIORARI TO THE  
UNITED STATES COURT OF APPEALS  
FOR THE THIRD CIRCUIT*

---

**BRIEF FOR THE UNITED STATES  
AS AMICUS CURIAE SUPPORTING PETITIONER**

---

**INTEREST OF THE UNITED STATES**

This case involves an application of the preemption provision of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144. The court of appeals construed that provision to mean that a state law regulating insurance may be applied to uninsured employee benefit plans, so long as the law does not regulate what the court termed "core ERISA concerns." Pet. App. A19. The Secretary of Labor enforces the reporting, disclosure, and fiduciary obligations that ERISA imposes on private employee benefit plans. She therefore has a strong interest in the proper interpretation of ERISA's preemption provision, which Congress enacted to promote the development of private pension and welfare

plans and to assure uniform regulation of such plans. Moreover, the decision of the court below is inconsistent with Department of Labor opinion letters concluding that state insurance laws are preempted insofar as they apply to uninsured plans. See pages 18-19 and note 13, *infra*.

### STATUTORY PROVISIONS INVOLVED

Section 514(a) of ERISA, 29 U.S.C. 1144(a)—the basic preemption clause—provides:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

Section 514(b)(2)(A) of ERISA, 29 U.S.C. 1144(b)(2)(A)—the “savings clause”—provides:

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

Section 514(b)(2)(B) of ERISA, 29 U.S.C. 1144(b)(2)(B)—the “deemer clause”—provides:

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment

company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

### STATEMENT

1. Petitioner FMC Corporation operates the FMC Salaried Health Care Plan, an employee welfare plan within the meaning of Section 3(1) of ERISA, 29 U.S.C. 1002(1). The Plan provides health benefits to FMC employees and their dependents. FMC does not purchase a group insurance policy from an insurance company in order to provide benefits under the Plan, but instead pays benefits from its general assets. Pet. App. A2-A3, C1, C10.

Respondent Cynthia Ann Holliday is the daughter of Gerald Holliday, an FMC employee and subscriber to the Plan. She was seriously injured as a passenger in an automobile accident and the Plan paid substantial medical expenses on her behalf.<sup>1</sup> In accordance with the Plan's subrogation clause, Mr. Holliday signed a “third-party reimbursement form” agreeing that if he brought a liability claim against any third party, he would include benefits payable by the Plan

<sup>1</sup> Ms. Holliday's medical expenses totalled more than \$178,000 by 1989. The first \$10,000 of her medical expenses were paid by Mr. Holliday's automobile insurer. Pet. App. A2-A3. It is not clear from the record what portion of the remainder was paid by the Plan, although the amount exceeds \$67,000. C.A. App. 67a. It appears that the Hollidays also obtained recovery from Pennsylvania's Catastrophic Loss Trust Fund. See Br. in Opp. 3: 75 Pa. Cons. Stat. Ann. §§ 1761 *et seq.* (Purdon 1989) (repealed December 12, 1988). The Hollidays have not alleged that they have paid any of the medical expenses.



in his claim and would reimburse the Plan for the benefits provided. Pet. App. A3-A4, C1-C2.<sup>2</sup>

Mr. Holliday brought a negligence action on behalf of his daughter in Pennsylvania state court against the driver of the automobile in which she was injured. The parties entered into a settlement of that action under which respondent is entitled to \$49,875.50 plus accrued interest.<sup>3</sup> While the action was pending,

<sup>2</sup> Because the courts below held that the Plan's subrogation provision is void under Pennsylvania law and that the state law is not preempted by ERISA, they did not consider the precise meaning of the subrogation provision or its application to the facts of this case. In our view, federal common law properly applies in construing a subrogation clause in an employee benefit plan covered by ERISA. See 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits), reprinted in 3 Staff of Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare, 94th Cong., 2d Sess., *Legislative History of the Employee Retirement Income Security Act of 1974*, at 4670-4671 (Comm. Print 1976) ("[i]t is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans"); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (recognizing Congress's "expectation[] that a federal common law of rights and obligations under ERISA-regulated plans would develop"). While it is not appropriate at this time to determine the rule that should apply as a matter of federal law, it should be noted that, under general principles of subrogation law, FMC would not be allowed to obtain full reimbursement out of a tort recovery if the Hollidays had not been made whole. See R. Jerry, II, *Understanding Insurance Law* 467 (1987). Instead, if the family was required to pay some of Ms. Holliday's medical expenses, then the subrogation clause would be construed either to call for prorating the tort recovery between FMC and the Hollidays, or to call for FMC to recover only the amount in excess of the family's payments. *Ibid.*

<sup>3</sup> The parties to the negligence action settled the case after the defendant driver interpleaded his \$100,000 automobile

FMC notified the Hollidays that it would seek reimbursement for the amounts it had paid for respondent's medical expenses. The Hollidays informed FMC that they would not reimburse the Plan, asserting that Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law, 75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1989), precludes subrogation by FMC. Pet. App. A3-A5, C2-C3.<sup>4</sup>

2. Petitioner then filed this declaratory judgment action in federal district court. On cross motions for summary judgment, the district court held, first, that "if it is not preempted, § 1720 of the Pennsylvania law would prohibit FMC's exercise of subrogation rights in any amount Holliday recovered" on his claim against the driver. Pet. App. C7.

The court then ruled that Section 514 of ERISA, 29 U.S.C. 1144, does not preempt application of the state statute. The court noted that Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan," and that the "Pennsylvania law 'relates to' the Plan." Pet. App. C7, C8. However, the court added, the saving clause, Section 514(b)(2)(A), provides that ERISA does not "exempt or relieve any person from any law of

policy in favor of Ms. Holliday and three other claimants injured in the accident. Pet. App. A3. Under the terms of the state court order approving the settlement, Ms. Holliday's recovery is being held in escrow pending the outcome of this case. Pet. 5 n.3.

<sup>4</sup> Section 1720 states as a general rule that "[i]n actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery." There is no exception barring double recovery. Thus, even if the Plan had paid all of Ms. Holliday's medical expenses, it would be barred by Section 1720 from asserting any subrogation rights.

any State which regulates insurance,” and “the parties have agreed that this law regulates insurance.” Pet. App. C7, C10.

The district court then turned to the “deemer clause,” Section 514(b)(2)(B), which provides that “[n]either an employee benefit plan \* \* \* nor any trust established under such a plan, shall be deemed to be an insurance company \* \* \* or to be engaged in the business of insurance \* \* \* for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts.” The court recognized that “FMC provides the funds needed to pay any medical benefits due under the Plan out of its own assets,” and that, in light of the deemer clause, “a number of courts have held that certain state laws regulating insurance are nonetheless preempted as they apply to self-insured plans.” Pet. App. C10, C11. Indeed, as the district court acknowledged (*id.* at C11), this Court in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 747 (1985), in upholding application of a state law requiring insurance companies to provide certain benefits in any policy they issue, stated that it was “aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not.” However, relying on *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85, 93 (6th Cir.), cert. denied, 486 U.S. 1017 (1988), and “certain aspects of the legislative history,” the district court held that “the effect of the deemer clause should be assessed by a balancing of the interests in federal uniformity against those of state primacy in the regulation of insurance.” Pet. App. C13. The court then concluded that the state interest outweighed the federal interest because preemp-

tion “would encroach upon state law in an area in which states enjoy ‘general authority and autonomy’—insurance regulation.” *Id.* at C14 (citing *Northern Group Services*, 833 F.2d at 93-94).

3. The court of appeals affirmed. Pet. App. A1-A27. On the preemption issue,<sup>5</sup> the court of appeals recognized that the case “turns on whether FMC’s Salaried Health Plan falls within the deemer clause exception insulating employee plans from state regulation.” *Id.* at A18. The court held that Section 1720 is not preempted because, it concluded, “the deemer clause is meant mainly to reach back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation.” Pet. App. A19.

In support of that construction of the statute, the court of appeals noted that the deemer clause refers to “any state law ‘purporting’ to regulate insurance.” Pet. App. A19. The court added that two comments on the floor of Congress “displayed concern for pretextual state infringements.” *Ibid.* Furthermore, the court found significance in the fact that the deemer clause first appeared in a version of the bill that would have preempted only those laws “relat[ing] to the reporting and disclosure responsibilities, and fiduciary responsibilities, of persons acting on behalf of any [covered] employee benefit plan”; the court said that “the retention of the deemer clause in the face of the expanded preemption clause indicates that the deemer clause in effect was meant to do the more narrow, specified work which the original version of

<sup>5</sup> The court of appeals also affirmed the lower court’s ruling that Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law, if not preempted, bars FMC from enforcing the subrogation provision. Pet. App. A5-A10. Petitioner has not sought review of that holding, which involves a question of state law.



the preemption clause was meant to do.” *Id.* at A20, A23. Finally, the court dismissed this Court’s statement in *Metropolitan Life* that uninsured plans are not subject to state regulation on the ground that “the Court cited neither statutory text nor legislative history,” but instead “rel[ie]d on vague language in Congress’ *post hoc* study” of the effect of the preemption provision. *Id.* at A25.

The court of appeals similarly dismissed, as erroneously relying on “Supreme Court dicta,” the numerous decisions of other courts of appeals holding that “the deemer clause incorporates a bright line distinction between employee benefit plans that purchase insurance and those, like FMC’s, which are self-insured.” Pet. App. A24. In any event, the court said, citing *Northern Group Services* (833 F.2d at 94-95), “the distinction between insured and self-insured plans does not disappear” under its construction of the preemption clause. Pet. App. A26. Rather, “insured plans would *per se* survive the deemer clause, while self-insured plans would merely be considered on a case-by-case basis as to whether the state regulation involved affects a central concern of ERISA.” *Id.* at A26-A27.

#### SUMMARY OF ARGUMENT

The courts below erred by failing to conclude that the deemer clause prohibits state regulation of uninsured employee benefit plans. Indeed, that is the only reasonable interpretation of Section 514. The basic preemption provision, Section 514(a), broadly preempts state law, while the saving clause, Section 514(b)(2)(A), excepts laws regulating insurance from preemption. The deemer clause makes clear that uninsured employee benefit plans are not to be

considered insurance companies, and hence are not within the saving clause’s exception to preemption.

1. This Court adopted that straightforward reading of Section 514 in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985). The Court held that insured employee benefit plans may be indirectly regulated by the States in that they may regulate the terms of insurance offered to those plans by insurance companies. The Court explicitly recognized that its “decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not.” *Id.* at 747. The Secretary of Labor, whose interpretation is entitled to deference, has also long construed Section 514 to protect uninsured employee benefit plans from state regulation.

2. The court of appeals’ interpretation of Section 514, in contrast, has no basis in the language of the statute itself. The court suggested (Pet. App. A19) that because the deemer clause refers to laws “purporting to regulate” insurance, Congress was concerned only with pretextual attempts to regulate employee benefit plans. This is, at best, a strained and unnatural reading of the statute. By that language, Congress merely intended to emphasize that a law applying to insurance companies would not extend to uninsured employee benefit plans. Moreover, the test devised by the court of appeals does not distinguish pretextual regulations from other state laws, but focuses on whether “core ERISA concerns” (Pet. App. A19) are at issue.

Nor does the legislative history support the court of appeals’ construction. Indeed, the court’s use of that history (Pet. App. A23) flies directly in the face of the clearly expressed purpose of Congress.



The fact that the deemer clause originated in a bill providing for more limited preemption does not remotely suggest that the deemer clause continued to have limited preemptive effect when the scope of preemption mandated by the bill was expanded. To the contrary, the authors of the expansive preemption provision stressed its breadth, and the language of the deemer clause reflects that breadth by providing that "any law of any State purporting to regulate insurance companies [or] insurance contracts" is preempted insofar as it applies to uninsured plans. Moreover, the court of appeals' construction of the statute gives Section 514(a) a very limited effect—under that construction, state insurance laws may regulate insured employee benefit plans to an unlimited extent and may *also* regulate uninsured plans except for regulation that infringes on ERISA's "core" areas.

3. The court of appeals' approach is also defective in that it threatens to encourage litigation over whether a state insurance law affects a "core" area. One of the virtues of the approach Congress adopted by enacting a broad preemption provision, along with the bright-line distinction between insured and uninsured plans recognized by this Court in *Metro-politan Life*, is that such litigation may be avoided. In addition, Congress enacted ERISA's broad preemption provision in order to allow plan designers to tailor plans to the needs of the beneficiaries and the sponsors, and to ensure that multistate plans would not be subject to inconsistent regulation. The court of appeals' holding directly conflicts with those goals, since FMC's reasonable decision to pay health benefits to victims of automobile accidents, while insisting on reimbursement if a tort recovery is obtained, is overruled in those States that prohibit sub-

rogation clauses. The statute does permit inconsistent regulation with respect to plans that choose to obtain insurance, but that result logically follows from Congress's decision broadly to preempt state law while preserving the States' traditional role as the primary regulators of insurance companies.

## ARGUMENT

### ERISA'S "DEEMER CLAUSE" PROHIBITS STATE REGULATION OF UNINSURED EMPLOYEE BENEFIT PLANS

The courts below correctly held (Pet. App. A13-A15, C8-C9) that Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law, as applied to bar FMC's assertion of subrogation rights, "relate[s] to" an employee benefit plan and thus falls within the "expansive sweep" (*Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 47 (1987)) of ERISA's basic preemption provision. As the court of appeals noted (Pet. App. A13-A15), the Pennsylvania law clearly has "a connection with or reference to" FMC's plan (*Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)) since, by the terms of the plan document, FMC has a right of recoupment from a subsequent tort recovery.<sup>6</sup> The Pennsylvania law overrides that right, requiring the Plan to assume ultimate responsibility for payment of benefits even

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<sup>6</sup> A subrogation provision such as FMC's is a reasonable and permissible method of reducing an employee benefit plan's costs while ensuring that beneficiaries' primary needs are covered. See R. Jerry, *supra*, at 464; compare *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (upholding pension plan provision reducing retirement benefits by the amount of any workers' compensation award).

where the beneficiary recovers medical expenses from a third party.<sup>7</sup>

The court of appeals also correctly concluded (Pet. App. 16-18, C9-C10) that the Pennsylvania statute falls within Section 514's saving clause, which exempts from preemption state laws "which regulate[] insurance." Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A). The Pennsylvania statute regulates "the business of insurance" as those terms have been construed under ERISA's saving clause and the McCarran-Ferguson Act. By regulating subrogation rights, the state law transfers a policyholder's risk (in this instance, *back* to FMC), affects an integral part of the policy relationship between an insurer and insured, and is aimed principally at a practice of the insurance industry. See *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 743 (1985).<sup>8</sup> The main effect of the law, in other words,

<sup>7</sup> Other courts have concluded that similar state laws "relate[] to" employee benefit plans. See *United Food & Commercial Workers v. Pacyna*, 801 F.2d 1157, 1160 (9th Cir. 1986) (Arizona common law prohibition against subrogation "relates to" an employee benefit plan); *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85, 89 (6th Cir. 1987), cert. denied, 486 U.S. 1017 (1988) (coordination of benefits provision of Michigan no-fault automobile liability statute falls within preemptive scope of Section 514(a)); see also *Shaw*, 463 U.S. at 95-100 (mandated benefits law "relate[s] to" employee benefit plan); *Alessi*, 451 U.S. at 524 (ERISA preempts New Jersey statute forbidding benefit plans from offsetting workers' compensation payments against employee pension benefits).

<sup>8</sup> Accord *Pacyna*, 801 F.2d at 1160-1161; *Northern Group Services*, 833 F.2d at 89-90 (coordination of benefits provision of Michigan no-fault automobile insurance law regulates insurance within the meaning of ERISA's saving clause);

is to prevent insurers from obtaining reimbursement, despite a contract calling for subrogation, where the beneficiary prevails in a tort action and obtains an additional recovery.

The courts below erred, however, by concluding that Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law is saved from preemption in this case. Although the saving clause excepts from preemption laws regulating insurance, the deemer clause makes clear that uninsured employee benefit plans are not subject to such laws. In this case, application of the Pennsylvania statute would have a major impact on FMC's uninsured Plan, since despite the clear language of the Plan, it would not be able to recoup its payments where recovery is obtained from a tortfeasor.

**A. As This Court Concluded In *Metropolitan Life*, Congress Authorized The States To Regulate Indirectly Those Employee Benefit Plans That Obtain Insurance But Did Not Authorize The States To Regulate Uninsured Plans**

1. A common-sense reading of Section 514 compels the conclusion that uninsured employee benefit plans are not subject to regulation by the States. By providing that ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan," Section 514(a) broadly preempts state law. *Pilot Life*, 481 U.S. at 47; *Shaw*, 463 U.S. at 97. Section 514(a) was intended "to foreclose any non-Federal regulation of employee benefit plans." 120 Cong. Rec. 29,197 (1974) (re-

contra *Barter v. Lynn*, 886 F.2d 182, 186 (8th Cir. 1989) (common law rules on subrogation are not the type of state insurance regulation intended to fall within scope of saving clause).



marks of Rep. Dent), *reprinted in* 3 Staff of Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare, 94th Cong., 2d Sess., *Legislative History of the Employee Retirement Income Security Act of 1974*, at 4670 (Comm. Print 1976) [hereinafter *Leg. Hist.*].<sup>9</sup>

The saving clause, Section 514(b)(2)(A), excepts insurance laws from the expansive preemption provision. Insurance companies have traditionally been subject to state regulation, and Congress in 1945 recognized the traditional primacy of the States by enacting the McCarran-Ferguson Act, which provides that "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxa-

<sup>9</sup> Section 514(a) was added by the Conference Committee after both houses had passed bills that preempted state laws only to the extent that they conflicted with certain matters regulated by ERISA. Representative Dent explained the Conference substitute by stating: "I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." 120 Cong. Rec. 29,197 (1974), *reprinted in* 3 *Leg. Hist.* 4670. Senator Williams similarly explained the Conference action, stating: "It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law." 120 Cong. Rec. 29,933 (1974), *reprinted in* 3 *Leg. Hist.* 4745-4746.

tion of such business." 15 U.S.C. 1012(a). The saving clause preserves the States' role as the principal regulator of the insurance industry.

However, in the deemer clause, Section 514(b)(2)(B), Congress made clear that, while state regulation of the insurance industry was not to be preempted, no employee benefit plan "shall be deemed to be an insurance company." "Consequently, a state may not regulate an employee benefit plan simply because the plan serves as self-insurer on all of its benefits. Thus, the deemer provision prevents a state from subjecting a plan, as a business of insurance, to the state's general insurance laws." *Wadsworth v. Whaland*, 562 F.2d 70, 77 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978).

The Court endorsed this straightforward reading of Section 514 in *Metropolitan Life*. The issue in that case was whether a state mandated-benefit law, as applied to policies purchased from insurance companies by employee health care plans, was saved from preemption by ERISA's saving clause. 471 U.S. at 727. Holding that the law was not preempted, the Court reasoned that a state law's regulation of the contracts sold by insurance companies is saved as a law which "regulates insurance," notwithstanding its indirect effect on employee benefit plans that enter into those contracts. The Court "decline[d] to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the 'deemer clause' which modifies it." *Id.* at 746.

The Court's holding in *Metropolitan Life* pertained directly to the effect of the saving clause on insured plans because, "[i]n light of ERISA's 'deemer clause,' \* \* \* Massachusetts ha[d] never tried to enforce [the state mandated benefit law] as



applied to benefit plans directly, effectively conceding that such an application of [state law] would be preempted." 471 U.S. at 735 n.14. Indeed, the Massachusetts Supreme Judicial Court, also recognizing that Section 514 bars regulation of uninsured employee benefit plans, had held that the part of the state law applicable to insurers was severable from the preempted portions pertaining directly to benefit plans. *Ibid.* In light of Massachusetts' concession, the Court's holding related to the saving clause, but in interpreting that clause the Court construed the deemer clause as an integral part of its analysis. Noting that the deemer clause specifically refers to "insurance contracts," this Court read the reference as indicating that the saving clause encompassed laws affecting insurance contracts: "Unless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans." *Id.* at 741.<sup>10</sup>

The Court recognized that the deemer clause precludes state regulation of uninsured employee benefit plans. It explained: "We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we

<sup>10</sup> See also 471 U.S. at 744 ("the plain language of the saving clause, its relationship to the other ERISA pre-emption provisions, and the traditional understanding of insurance regulation, all lead us to the conclusion that mandated-benefit laws such as [the Massachusetts statute] are saved from pre-emption by the operation of the saving clause") (emphasis added).

merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." 471 U.S. at 747.<sup>11</sup> Although no uninsured plan was at is-

<sup>11</sup> The Court knew that Congress was aware of the distinction between insured and uninsured plans because the matter had been addressed by the 1977 Activity Report of the House Committee on Education and Labor, which contains the report of a Congressional Pension Task Force established pursuant to ERISA to study ERISA preemption. The Report had stated that persons selling insurance policies may be subject to state regulation, but that "state action is barred" with respect to plans themselves. See 471 U.S. at 747 n.25 (quoting H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977)); see also *id.* at 47 ("the 'deemed' language was utilized to create an irrebuttable presumption that these [employee benefit] plans are not insurance, trust companies, etc., for purposes of state regulation").

In addition, in 1983 Congress created a limited exception providing that specified parts of a Hawaii health care statute enacted before ERISA are not preempted. 29 U.S.C. 1144 (b) (5), added by the Act of Jan. 14, 1983, Pub. L. No. 97-473, § 301(a), 96 Stat. 2611. The amendment was precipitated by an uninsured employee benefit plan's successful challenge to the Hawaii statute on the ground that it was preempted by ERISA. *Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981). Representative Erlenborn, the ranking minority member of the House Committee on Education and Labor, explained that Congress viewed the Hawaii law as "an unusual special case," and stated that "[i]n agreeing to the Hawaii exception this body will be reaffirming the broad scope of ERISA preemption and the validity of the interpretation of the Federal courts in connection with the Hawaii statute." 128 Cong. Rec. 30,356 (1982). Accordingly, Congress expressly declined to save any other similar state law, providing instead that the amendment "shall not be considered a precedent with respect to extending such amendment to any other State law." § 301(b), 96 Stat. 2612.

sue in *Metropolitan Life*, the Court's statement flows naturally both from the language of Section 514 and the Court's holding. Indeed, the Court's holding with respect to the scope of the saving clause was grounded in its understanding of the relationship of that clause to the basic preemption provision and the deemer clause.<sup>12</sup>

Like this Court, the Secretary of Labor consistently has interpreted the deemer clause to insulate uninsured employee benefit plans from state insurance regulation. Shortly after ERISA's enactment, the Secretary concluded that since the deemer clause "adopts a distinction between insurance and employee benefit plans," a state law was preempted in-

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<sup>12</sup> Following the lead of *Metropolitan Life*, the clear majority of the courts of appeals that have addressed the issue have held that ERISA preempts direct state regulation of uninsured employee benefit plans. *Barter v. Lynn*, 886 F.2d at 186; *Reilly v. Blue Cross & Blue Shield United*, 846 F.2d 416, 425 (7th Cir.), cert. denied, 488 U.S. 856 (1988); *Moore v. Provident Life & Accident Insurance Co.*, 786 F.2d 922, 927 (9th Cir. 1986) ("uninsured plans are regulated exclusively by the provisions of ERISA"); *Pacyga*, 801 F.2d at 1162; *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423 (4th Cir. 1985), cert. denied, 476 U.S. 1170 (1986); *Children's Hospital v. Whitcomb*, 778 F.2d 239, 242 (5th Cir. 1985) ("ERISA preempts the Louisiana [mandated-benefit] statute insofar as it relates to a self-insured plan, although it would not preempt if the plan were an insured plan."); accord *Insurance Board of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 411 (3d Cir. 1987) (*Metropolitan Life* "concluded that ERISA permitted states to regulate insurance policies purchased by plans from insurance companies, though ERISA did not permit states to regulate the plans themselves"); see also *Wadsworth v. Whaland*, 562 F.2d at 76 n.34. But see, in addition to the decision below, *Northern Group Services*, 833 F.2d at 95.

sofar as it "require[d] employers who have established self-insured plans for their own employees to meet requirements for insurance companies." United States Department of Labor, ERISA Opinion Letter No. 75-128, at 1 (June 20, 1975).<sup>13</sup> The Secretary's reasonable construction of the statute she administers is entitled to deference.<sup>14</sup>

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<sup>13</sup> See also ERISA Opinion Letter No. 78-3A, at 2 (Feb. 15, 1978) ("to the extent that the proposed act in the Utah State Legislature to regulate non-insured employee welfare benefit plans may be applicable by its terms to employee benefit plans covered by ERISA, the proposed Act would be preempted by § 514 of ERISA" because, "under § 514 (b) (2) (B) of ERISA, an employee benefit plan subject to ERISA may not be deemed to be an insurance company \* \* \* for the purpose of state laws purporting to regulate insurance companies [or] insurance contracts"); ERISA Opinion Letter No. 79-6A, at 3 (Jan. 16, 1979) ("[a]lthough state insurance laws are excepted from preemption by section 514(b) (2) (A), section 514(b) (2) (B), in effect, prevents a state from regulating an employee benefit plan simply because the plan self-insures its benefits"); ERISA Opinion Letter No. 82-003A, at 3 (Jan. 29, 1982) (Section 514 does not preempt application of a New Hampshire statute insofar as the statute "require[s] an insurance company to issue extended eligibility coverage to its policyholders, even though some such policyholders may be employee welfare plans," but does preempt the portion of the statute regulating self-insured plans).

<sup>14</sup> *Massachusetts v. Morash*, 109 S. Ct. 1668, 1673-1674 & n.14 (1989); *Blessitt v. Retirement Plan for Employees of Dixie Engine Co.*, 848 F.2d 1164, 1167 (11th Cir. 1988) ("we note that we owe great deference to the interpretations and regulations of the Pension Benefit Guaranty Corporation \* \* \*, the Internal Revenue Service \* \* \*, and the Department of Labor, which are the administrative agencies responsible for enforcing and interpreting ERISA"); see generally *Chevron U.S.A. Inc. v. Natural Resources Defense*



2. This straightforward reading of Section 514 stands in sharp contrast to the court of appeals' conclusion (Pet. App. A19) that the deemer clause is meant to preclude only state insurance regulation related to "core" ERISA concerns.<sup>15</sup> The only textual argument below was the court of appeals' comment that the deemer clause refers to state laws "purporting" to regulate insurance. *Ibid.* But its suggestion that by that term Congress meant to limit the effect of the clause to "pretextual" attempts to regulate ERISA plans represents a strained and unnatural reading of the statute. In our view, the term simply serves to emphasize that the deemer clause is an exception to the saving clause, and that laws applying to insurance companies do not directly govern employee benefit plans. Cf. Section 514(c)(2), 29 U.S.C. 1144(c)(2) ("[t]he term 'State' includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which *purports to regulate*, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter") (emphasis added).<sup>16</sup> In any event, the

*Council, Inc.*, 467 U.S. 837, 844 (1984); *Sullivan v. Everhart*, 110 S. Ct. 960, 961 (1990).

<sup>15</sup> In its only effort to define those concerns, the court of appeals referred to "such ERISA areas as reporting, disclosure, and nonforfeiture." Pet. App. A23.

<sup>16</sup> The court's emphasis upon the term "purporting" also is undercut by the legislative history of Section 514. The Conference Report's description of the deemer clause does not refer to the "purporting" language, strongly suggesting that the term does not have the overriding significance attributed to it by the court of appeals. See H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 383 (1974) ("[h]owever, the substitute generally provides that an employee benefit plan

court's interpretation of the provision's language as referring to pretextual attempts to regulate ERISA plans is unrelated to the preemption standard it ultimately adopted: "whether the state insurance regulation *intentionally or unintentionally* addresses a core type of ERISA matter which Congress sought to protect by the preemption provision." Pet. App. A27 (emphasis added).

Nor does the legislative history of Section 514 support the lower courts' decision. As noted (see note 9, *supra*), the Conference Committee broadened the preemptive scope of Section 514(a) while retaining the saving clause and the deemer clause contained in the bill that originally passed the House. See *Summary of Differences Between the Senate Version and the House Version of H.R. 2 to Provide for Pension Reform* 32-34 (June 12, 1974), reprinted in 3 *Leg. Hist.* 5282-5284. The conferees stressed that the revised preemption provision, "with the narrow exceptions specifically enumerated, \* \* \* foreclose[s] any non-Federal regulation of employee benefit plans." 120 Cong. Rec. 29,197 (1974) (remarks by Mr. Dent), reprinted in 3 *Leg. Hist.* 4670.<sup>17</sup> Relying on

is not to be considered as an insurance company (and is not to be considered as engaged in the business of insurance or banking) for purposes of any State law *that regulates* insurance-companies, insurance contracts, banks, trust companies, or investment companies") (emphasis added), reprinted in 3 *Leg. Hist.* 4650.

<sup>17</sup> Ignoring the thrust of the managers' comments, the court of appeals seized on two words (emphasized in the quotations below) in the remarks of two ERISA managers as support for its "pretextual" approach to the deemer clause. It referred (Pet. App. A19) to Senator Javits' statement that preemption applied to state laws "hastily *contrived* to deal with some particular aspect of private welfare or



the fact that the deemer clause was retained while the preemption provision was expanded, the court of appeals deduced that the deemer clause was intended to do "the more narrow, specified work which the original version of the preemption clause was meant to do" (Pet. App. A23); *i.e.*, the deemer clause protects only "core" ERISA areas from state regulation. But that extraordinary conclusion is wholly at odds with the clearly expressed purpose of the statute. It is directly contrary to the consistent recognition by this Court that the preemption provision was intended "to displace all state laws that fall within its sphere," even including state laws that are consistent with ERISA's provisions or that govern subjects not regulated by ERISA. See *Metropolitan Life*, 471 U.S. at 739; *Shaw*, 463 U.S. at 105 & n.25. It is also contrary to the statements of the conferees,

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pension benefit plans not clearly connected to the Federal regulatory scheme." 120 Cong. Rec. 29,942 (1974), *reprinted in 3 Leg. Hist.* 4770-4771. Of course, there is nothing in Senator Javits' statement indicating that preemption was limited to such "contrived" state laws, and such an implied restriction would make no sense in light of Congress's broad preemptive intent. Furthermore, and in direct contradiction of the court of appeals' ruling that state insurance law may govern "non-core" ERISA areas, Senator Javits emphasized that even state laws governing aspects of benefit plans "not clearly connected to the Federal regulatory scheme" are preempted. *Ibid.* Nor is the court of appeals' approach supported by Senator Williams' reference to "State professional associations acting under the guise of State-enforced professional regulation." 120 Cong. Rec. 29,933 (1974) (emphasis added), *reprinted in 3 Leg. Hist.* 4746. Like Senator Javits and Representative Dent, he stressed that, "with the narrow exceptions specified in the bill," the conference substitute "preempt[s] the field for Federal regulations." 120 Cong. Rec. 29,933 (1974), *reprinted in 3 Leg. Hist.* 4745.

who emphasized the breadth of the newly enacted preemption provision, without even a hint that the deemer clause was intended to perform the restrictive function of the abandoned House and Senate-passed versions of the basic preemption clause. It would have been a simple matter for the conferees to have inserted limiting language into the deemer clause had that been their intent.<sup>18</sup> Instead, they retained the broad language of the deemer clause referring to "*any* law of any State purporting to regulate insurance companies [or] insurance contracts" (emphasis added).<sup>19</sup>

Furthermore, the Conference Committee's expansion of the preemption provision would have little meaning under the court of appeals' approach. Under the court of appeals' rule, the States may regulate insured plans (as this Court held in *Metropolitan Life*), and they may also regulate uninsured plans pursuant to state insurance law, except for those areas at the "core" of ERISA. But that is essentially what the bills provided before the conference revision. Thus, the court of appeals' rule gives little meaning to the broad language of Section 514(a). Yet the conferees stressed, and this Court has repeatedly recognized, that Section 514(a) was

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<sup>18</sup> For example, the conferees could have revised the deemer clause so that it referred to state insurance laws regulating such matters as disclosure, vesting, and forfeitability.

<sup>19</sup> In *Metropolitan Life*, the Court "declin[ed] to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the 'deemer clause' which modifies it" (471 U.S. at 746). The Court concluded that the Massachusetts Supreme Judicial Court's "attempt to save only state regulations unrelated to the substantive provisions of ERISA" was inconsistent with the saving clause's terms. *Id.* at 746-747.

intended to have a broad effect. *Pilot Life*, 481 U.S. at 47; *Shaw*, 463 U.S. at 96-97.<sup>20</sup>

**B. State Insurance Regulation Of Uninsured Employee Benefit Plans Is Inconsistent With The Purposes Of ERISA's Preemption Provision**

The lower courts' decision interferes with Congress's intent to avoid "endless litigation over the validity of state action that might impinge on Federal regulation." 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits), *reprinted in 3 Leg. Hist.* 4770. As Senator Javits explained (*id.* at 4770-4771), one of the reasons the conferees broadened the scope of the preemption provision was to eliminate questions about whether a particular state law affected a matter specifically governed by ERISA. Instead, it adopted a bright-line test—if a plan is insured, indirect regulation pursuant to state insurance laws is permissible; if the plan is uninsured, regulation is not permitted. Congress hardly intended the deemer clause to preserve the questions it thought it was eliminating. Yet, the court of appeals' "core area" test plainly does exactly that.<sup>21</sup>

<sup>20</sup> The court of appeals suggested (Pet. App. A24) that unless its "core-area" standard were adopted, the deemer clause would "swallow" the saving clause. But that is simply not so. Under *Metropolitan Life*, the saving clause protects state insurance regulation over insurance contracts purchased by employee benefit plans that would otherwise fall prey to the sweep of the Act's basic preemption provision.

<sup>21</sup> The similar approach adopted by the Sixth Circuit in *Northern Group Services*—"the effect of the deemer clause should be assessed by a balancing of the interests in federal uniformity against those of state primacy in the regulation of insurance" (833 F.2d at 93)—has similar defects. In that case, the court of appeals held that Section 3109a of Michi-

In addition, this Court repeatedly has stressed that Congress intended Section 514 to relieve employers of potentially conflicting state requirements, thus fostering the development of employee benefit plans.<sup>22</sup> The lower courts' holding that the Pennsyl-

gan's no-fault automobile insurance law, Mich. Comp. Laws § 500.3109a (1983), is *not* preempted insofar as it requires the liability of no-fault insurers to be secondary to that of an uninsured employee benefit plan. In *Liberty Mutual Insurance Group v. Iron Workers Health Fund*, 879 F.2d 1384 (1989), however, the Sixth Circuit held that the same Michigan statute, Section 3109a, is preempted insofar as it prohibits an uninsured employee benefit plan from excluding automobile accident coverage altogether. Although the court in *Liberty Mutual* discussed *Northern Group Services* (see 879 F.2d at 1387 (noting that "[i]t would appear at first blush that *Northern Group Services* requires us to hold in this case that § 3109a is not preempted by ERISA")), it is not clear why the federal interest outweighed the state interest in the one case but not the other. It is clear, however, that under a test like the Sixth Circuit's or that of the court below, employee benefit plan funds will be expended in litigation over where the balance lies or whether a "core area" of ERISA is infringed.

<sup>22</sup> See *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987) ("[p]re-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations"); *Pilot Life*, 481 U.S. at 45-46 ("the express pre-emption provisions of ERISA are deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern'"); *Metropolitan Life*, 471 U.S. at 739 ("[t]he pre-emption provision was intended to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA's substantive requirements"); *Shaw v. Delta Airlines, Inc.*, 463 U.S. at 105 & n.25 ("Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees").



vania statute can be applied to bar petitioner's subrogation rights would frustrate Congress's purpose of freeing plans from state regulation. Through ERISA, Congress intended to leave decisions concerning the content of plans "to the discretion of \* \* \* plan designers" (*Alessi*, 451 U.S. at 525), unimpeded by state regulation that could thwart plan growth.<sup>23</sup> Moreover, divergent state regulation would preclude plan administrators from "establish[ing] a uniform administrative scheme \* \* \* [with] a set of standard procedures to guide processing of claims and disbursement of benefits." *Fort Halifax Packing Co.*, 482 U.S. at 9. Such a "patchwork scheme of [state] regulation" would "introduce considerable inefficiencies" in benefit plans, and might lead employers to reduce benefits. *Id.* at 10-11.

These concerns are directly implicated here. By virtue of the court of appeals' holding, FMC administrators can no longer operate their plan through a single administrative scheme. Rather, the viability of this multistate Plan's subrogation provision will depend upon its validity under the law of each State in which the Plan does business. Even more importantly, the lower court's holding thwarts the reasonable choice of FMC Plan designers to provide medical benefits for auto accident injuries on the condition that the Plan can recoup its outlays where there has been recovery from a negligent third party. State law preclusion of that choice clearly increases

<sup>23</sup> While freeing plan designers from state law restrictions, Congress did impose some significant restrictions of its own. For example, pension plans must be separately funded according to requirements set out in 29 U.S.C. 1082, and benefits must vest according to a schedule set out in 29 U.S.C. 1053.

the Plan's costs for accident-related benefits. As a result, the Plan's designers might make a downward adjustment in benefits or otherwise revise its program of personal injury protection for accidents. As this Court has noted, "ERISA's comprehensive preemption of state law was meant to minimize this sort of interference with the administration of employee benefit plans." *Shaw*, 463 U.S. at 105 n.25.<sup>24</sup>

To be sure, Congress intended to preserve traditional state authority over the insurance industry by virtue of the saving clause. See *Metropolitan Life*, 471 U.S. at 740-741. The relationship between the saving clause and the deemer clause, however, implements that congressional intent while preserving the freedom from state control that Congress envisioned for benefit plans. Employers that purchase insurance for the provision of employee benefits do so with the understanding that those insurance contracts may be subject to state regulation.<sup>25</sup> At the same time, em-

<sup>24</sup> The court of appeals' proviso that state insurance law may regulate only "non-core" ERISA areas (Pet. App. A19) does not go far enough to satisfy the underlying purposes of the statute. As this Court's decisions make abundantly clear (*Metropolitan Life*, 471 U.S. at 739; *Shaw*, 463 U.S. at 98-99 & nn.18-20), ERISA preemption extends to state laws that regulate plan contents even in areas left unregulated by ERISA. Thus, Congress's intent to occupy the field is not dependent upon whether the State has attempted to regulate an area specifically regulated by ERISA. Rather, as the preemption provisions establish, there is an overriding ERISA interest in freeing plans from direct state regulation.

<sup>25</sup> In that situation, the insurance company that sold the policy—which should be accustomed to inconsistent regulation in light of the long tradition of state primacy in the area of insurance regulation—would presumably assist the purchaser in adjusting to the differing rules of the various



ployers may choose to set up uninsured plans, which will allow them to operate on a field of federal uniformity. Although the district court suggested that the distinction between insured and uninsured plans is illogical (Pet. App. C11-C12), it in fact represents a salutary and workable accommodation between state insurance regulation and federal preemption.

### CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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APRIL 1990

States. Indeed, the insurance company would bear most of the burden of adjustment itself—a burden that would be reflected at the outset in the announced cost to the purchaser.

No. 89-1048

Supreme Court, U.S.

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JOSEPH E. SPANIEL, JR.  
CLERK

IN THE  
**Supreme Court of the United States**  
OCTOBER TERM, 1989

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FMC CORPORATION,  
*Petitioner,*  
v.

CYNTHIA ANN HOLLIDAY,  
*Respondent.*

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On Writ of Certiorari to the  
United States Court of Appeals  
for the Third Circuit

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BRIEF AMICUS CURIAE OF  
THE SELF-INSURANCE INSTITUTE OF AMERICA, INC.  
IN SUPPORT OF THE PETITIONER

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IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1989

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No. 89-1048

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FMC CORPORATION,  
v. *Petitioner,*  
CYNTHIA ANN HOLLIDAY,  
*Respondent.*

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**On Writ of Certiorari to the  
United States Court of Appeals  
for the Third Circuit**

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**BRIEF AMICUS CURIAE OF  
THE SELF-INSURANCE INSTITUTE OF AMERICA, INC.  
IN SUPPORT OF THE PETITIONER**

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The Self-Insurance Institute of America, Inc. ("SIIA") submits this *amicus curiae* brief with the consent of both FMC Corporation and Cynthia Ann Holliday.<sup>1</sup>

**INTEREST OF THE AMICUS**

SIIA is a non-profit corporation composed of over 700 members dedicated to the advancement and protection of the self-insurance industry. SIIA's membership includes users of self-insurance such as employer plan sponsors, as well as service providers

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<sup>1</sup> Original consent letters from both FMC Corporation and Cynthia Ann Holliday have been lodged with the Court.

such as third-party administrators, reinsurance companies, and other entities engaged in the self-insurance business. SIIA is the only association in the U.S. which represents firms, professionals, and organizations which participate in the broad spectrum of self-insurance, including self-insured group health plans.

Through SIIA, its members coordinate their views and provide practical information and recommendations to government and the public on how the self-insurance system functions, and on the impact of government regulations and interpretations under the Employee Retirement Income Security Act of 1974, ("ERISA") 29 U.S.C. §§ 1001 *et seq.*, concerning self-insured health plans and plan participants. This includes rendering assistance to courts in their deliberations on significant self-insured health plan issues of broad concern to members.

SIIA has an interest in the ERISA preemption issue presented in this case—whether a state anti-subrogation law applies to a self-insured health benefit plan—for three reasons. First, the issue presented is of major concern to the self-insurance industry because the rising cost to employers of providing health benefits will escalate further if states may prohibit member companies from including subrogation provisions in their plans similar to the clause invalidated by the Third Circuit. This will result either in reduced health care benefits, or higher out-of-pocket costs for participants in the form of higher co-payments and deductibles, or both. The Third Circuit's decision may even threaten the continued viability of self-insurance as a cost-efficient alternative for providing health benefits to millions of employees. Second, because many SIIA employer members

operate on a multi-state basis, they are legitimately concerned that any erosion of ERISA's preemption provisions will not only severely disrupt the operation of their plans but will also open the door to additional state insurance regulation which will severely hamper their efforts to administer their plans on a uniform and cost-efficient basis—precisely the objectives Congress sought to achieve through federal preemption. Third, if state anti-subrogation statutes apply to employee benefit plans, the risk of loss for injuries caused by third parties will needlessly shift to employer-sponsored plans thus creating a "wind-fall" for employees who receive duplicative recoveries from the responsible party.

Accordingly, SIIA files this *amicus curiae* brief in support of the petitioner.

#### SUMMARY OF ARGUMENT

In concluding that the Pennsylvania anti-subrogation law applies to an uninsured health plan, the court of appeals overlooked the scope and purpose of ERISA's so-called "deemer" clause which insulates self-funded plans from state law. By finding that ERISA'S deemer clause was applicable only when state laws affected undefined "core ERISA concerns", the court of appeals contrived a vague new judicial standard which ignores ERISA's express goal of promoting uniform employee benefit regulation. This finding is unsupportable in light of ERISA's explicit preemption language and its legislative history. The court of appeals also failed to recognize the time-honored distinction between conventional insurance and self-insurance which was codified by Congress in ERISA's deemer clause and which has been consistently recognized by this Court.



The Third Circuit's decision creates an ill-conceived precedent which directly affects thousands of self-funded health plans which provide benefits to millions of participants. Since the passage of ERISA, SIIA members have established and administered self-funded plans in reliance upon a federal legal framework which expressly recognizes the distinction between insurance and self-insurance. SIIA members are deeply concerned that state anti-subrogation statutes which prevent recovery of duplicative health benefit payments will result in a "windfall" to participants who receive such payments and a "dead loss" to self-funded plans. This will significantly increase overall health plan costs and will have detrimental implications both for participants who will bear the ultimate cost-shifting burden of those costs, and for the continued growth of self-insured health benefit programs as a viable and cost-efficient alternative to conventional insurance.

#### ARGUMENT

##### I. THE THIRD CIRCUIT FAILED TO RECOGNIZE THE DISTINCTION BETWEEN INSURANCE AND SELF-INSURANCE WHICH WAS CODIFIED BY CONGRESS IN ERISA

In holding that a state insurance law applies to a self-funded health plan, the Third Circuit ignored ERISA's express statutory language and this Court's holding in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) that the deemer clause exempts such benefit plans from state regulation. As this Court pointed out in *Metropolitan Life*, "uninsured" employee benefit plans are not open to even "indirect regulation" under state law. 471 U.S. at 746-47.

There can be no serious dispute that the distinction between insurance and self-insurance was recognized by Congress when it enacted ERISA's deemer clause:

Neither an employee benefit plan nor any trust established under such plan shall be deemed to be an insurance company . . . for the purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts.

29 U.S.C. § 1144(b)(2)(B). Interpreting this provision in *Metropolitan Life* (involving a Massachusetts statute which mandated minimum mental health care benefits), this Court held that ERISA did not preempt the state insurance law as applied to *insured* health plans but that *uninsured* employee benefit plans were exempted from the state statute's reach. *Metropolitan Life*, 471 U.S. at 738-47. This Court concluded:

Our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing, we merely give life to a distinction Congress is unaware of and one it has chosen not to alter.

*Id.* at 747. Thus, while a state anti-subrogation law such as the Pennsylvania statute involved in this case may apply to an insurance contract or indirectly to a plan which purchases an insurance contract, it cannot apply to a self-funded plan.

ERISA codified this well-established distinction in 1974 when it adopted a broad preemption provision. ERISA Section 514(a) provides quite simply and directly that the provisions of Titles I and IV of ERISA shall preempt "any and all State laws inso-

far as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Although Congress sought uniform federal regulation of benefit plans, state laws regulating insurance were exempted from the broad preemption provision under the so-called "savings clause" in Section 514(b)(2)(A) which was intended to preclude ERISA preemption in areas reserved to the traditional state regulation of the "business of insurance." 29 U.S.C. § 1144(b)(2)(A). See McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.* (1976).<sup>2</sup> However, Congress added Section 514(b)(2)(B), the deemer clause, which limits the scope of the insurance savings clause and prohibits state regulation of self-funded plans.

It is well settled that where, as in the deemer provision, "Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of a contrary legislative intent." *Andrus v. Glover Construction Co.*, 446 U.S. 608, 616-17 (1980). That contrary intent is not to be found in the legislative history of ERISA. Instead, ERISA and its legislative

<sup>2</sup> In enacting McCarran-Ferguson, Congress declared that "the continued regulation of the *business of insurance* is in the public interest." 15 U.S.C. §§ 1011-1015. In enacting ERISA, Congress reserved to exclusive Federal authority the regulation of the field of employee benefit plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 120 (1983). Note that drawing upon the "analysis of the McCarran-Ferguson Act," the Eighth Circuit distinguished subrogation from the "business of insurance," stating that: "The practice of subrogation does not transfer the risk from a policyholder to his or her insurer. Rather, it limits the recovery available to the policyholder by preventing a double recovery." *Barter v. Lynn*, 886 F.2d 182, 186, *reh'g denied*, — F.2d — (8th Cir. 1989).

history explicitly—indeed, unqualifiedly—show that Congress knew exactly what it wanted to accomplish in Section 514(b)(2)(B) to prevent the savings clause from leading to a characterization of employee benefit plans as insurance companies—and used unmistakably plain language to achieve that objective.<sup>3</sup>

In concluding that ERISA does not insulate self-funded health plans from state regulation, the Third Circuit ignored the plain language of the deemer clause and instead fashioned a new judicial standard to invalidate the subrogation provision. Contrary to the great weight of authority upon which the self-insurance industry has relied,<sup>4</sup> the Third Circuit con-

<sup>3</sup> Faced with the conflicting and uncertain basis for regulation among the states, the "deemer" language was utilized to create an *irrebuttable presumption* that these plans are not insurance trust companies, etc., for purposes of state regulation . . . . The irrebuttable presumption would not be overcome even if an employee benefit plan engages in activities which bring it within the insurance . . . activities generally regulated by a state. Activity Report of the Committee on Education and Labor, Rpt. No. 91-1785 (January 3, 1977) (Emphasis Added).

<sup>4</sup> See *Barter v. Lynn*, 886 F.2d 182, *reh'g denied*, — F.2d — (8th Cir. 1989); *Reilly v. Blue Cross and Blue Shield of Wisconsin*, 846 F.2d 416 (7th Cir. 1988), *cert. denied*, 109 S.Ct. 145 (1988); *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986); *Children's Hospital v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985); *Standard Oil of California v. Agsalud*, 633 F.2d 760 (9th Cir. 1979), *aff'd mem.*, 454 U.S. 801 (1981); *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir. 1978), *cert. denied*, 439 U.S. 831 (1978). In *Insurance Board of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987),



cluded that the deemer clause exempts self-funded health plans from state laws only in cases where the state law affects a "central concern of ERISA." *FMC Corp. v. Holliday*, 885 F.2d 79, 89, *reh'g denied*, — F.2d — (3d Cir. 1989). This interpretation is contrary to ERISA's broad preemption provision and cannot be supported by a reading of ERISA's legislative history relating to preemption.

Indeed, in the final compromise version of ERISA, the Conference Committee rejected the narrow approach taken to preemption in earlier versions of ERISA and agreed on a substitute that was ultimately enacted into law. ERISA Leg. Hist., Vol. III at 4518.<sup>5</sup> Whereas earlier versions limited preemption to specific enumerated areas or to "the subject matters" regulated by federal law, the substitute elected deliberately to preempt all state laws "as they may now or hereafter relate to any employee benefit plan" subject to certain enumerated exceptions. In short, "Congress made a clear-cut decision not to identify various subjects on which state laws were to be preempted, but instead sought to avoid constant litigation over the scope of preemption by preempting, with certain limited exceptions, 'all' state laws insofar as they 'relate' to plans covered by ERISA." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987). *Pervel Industries, Inc. v. Connecticut Commission on Human Rights*, 468 F. Supp. 490, 492

the Third Circuit itself has also held that ERISA preempts state insurance law as applied to self-insured health plans.

<sup>5</sup> Citations to "ERISA Leg. Hist." refer to the separately bound legislative history: Senate Comm. on Labor and Public Welfare, Subcomm. on Labor, 94th Cong., 2d Session, Legislative History of ERISA (Three Volumes) (1976).

(D. Conn. 1978), *aff'd*, 603 F.2d 214 (2nd Cir. 1979), *cert. denied*, 444 U.S. 1031.

ERISA's original language limiting preemption "only to state laws relating to specific subjects regulated by ERISA," was amended to reflect Congress' desire to preempt the entire field with regard to benefit plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 104. ERISA preemption "is not to be limited to those state laws which deal specifically with ERISA plans or with subject matters covered by ERISA plans". *Baxter v. Lynn*, 886 F.2d at 195.

That this shift in approach adopted by the Conference Committee was a clear-cut and well thought-out decision is seen from the explicit statement made by Senator Jacob Javits, the ranking minority member of the Senate Committee on Labor and Public Welfare, who stated:

Both House and Senate bills provided for preemption of State law, but—with one major exception appearing in the House bill—defined the perimeters of preemption in relation to the areas regulated by the bill. Such a formulation raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme.

Although the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interest of



uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs.

ERISA Leg. Hist. Vol. III at 4770-71. Thus, the Third Circuit's flawed reliance on a "core ERISA concern" test was explicitly rejected by Congress.

## **II. LIMITING THE SCOPE OF THE DEEMER CLAUSE WILL ADVERSELY AFFECT SELF-FUNDED HEALTH PLANS AND PLAN PARTICIPANTS**

### **A. Health Plan Costs Will Increase**

ERISA's preemption language provides a significant impetus for companies to self-fund employee health benefits. Congress helped foster the favorable federal legal regulatory environment that has resulted in a phenomenal growth of self-funded plans.<sup>6</sup> This growth also reflects recognition of self-insurance as a viable alternative to conventional insurance for funding health benefits, and as a cost-efficient method of providing expanded benefit coverage during a period of rapidly escalating health costs.<sup>7</sup>

<sup>6</sup> According to a survey by Foster Higgins & Co. Inc., fifty-two percent of employers surveyed in mid-1989 self-insure their group health plans, up from 48% in mid-1988. Woolsey, *Most Health Plans Now Self-Funded*, Business Insurance, January 29, 1990 at 3. More than 50 percent of the U.S. workforce covered by group health plans participate in self-funded plans. *Self Insured Health Plans*, HCFA Review, Vol. 8 No. 2 (1986). The HCFA study also found that 74 percent of all firms with 1,000 to 4,999 employees self-fund their health benefits. The Foster Higgins survey found that 84% of employers with 20,000 or more workers self-funded their health plans in 1989, up from 73% in 1988. Foster Higgins at 10.

<sup>7</sup> In 1989, employers that self-insured health benefits reported much smaller cost increases than employers who pur-

An important factor which has contributed to this growth within the present federal regulatory framework is the flexibility of plan design. Subrogation clauses, a feature commonly found in employer-sponsored self-funded plans, are designed to preserve plan assets which can be used to pay enhanced benefits by allowing recovery of medical expenses which are the financial responsibility of other parties.<sup>8</sup> Generally, subrogation provisions permit plan recoveries for medical expenses paid by a plan for injuries sustained in automobile accidents, from product defects, in accidents on private or public property or for malpractice by hospitals and doctors, where such expenses are also payable to participants pursuant to legal action or settlement in civil cases. Subrogation recoveries do not reduce medical expenses which are otherwise paid to participants in the absence of a third party recovery. They simply eliminate duplicative payments, and preserve limited benefit dollars which are used to pay expanded health care benefits to participants.

chased health plans from commercial insurers. Plan costs for self-funded employers rose 17.6% in 1989 to an average of \$2,587 per employee from \$2,200 in 1988. By contrast costs for insured health plans leaped 22.7% in 1989 to an average of \$2,608 per employee from \$2,125 in 1988. Foster Higgins, *supra* note 6 at 75.

<sup>8</sup> Duplicate Medicare payments are also subject to recovery from beneficiaries by the Health Care Financing Administration for injuries already reimbursed by automobile and liability insurance. See, generally, CCH Medicare and Medicaid Guide ¶ 4142 (Vol. 1 at p. 1372); HCFA Reg. §§ 411.20 *et seq.*, CCH Medicare and Medicaid Guide ¶ 20, 881.32 to .54 (Vol. 4, pp. 8264-8274).

State anti-subrogation laws will, however, result in less money in plans to pay medical benefits thus forcing many employers to reduce or eliminate certain benefits. For example, faced with higher costs, employers are likely to restrict coverage for medical expenses related to negligent third-party injuries or to eliminate coverage for other benefits such as vision and dental care. In other cases, in order to maintain current benefit coverages and levels, higher plan costs will be shifted to plan participants in the form of higher co-payments and larger deductibles. Inevitably, state interference with sound cost-containment practices such as subrogation clauses will threaten the continued viability of self-insurance as an acceptable method of providing health benefits to participants.

#### **B. The Administrative Burdens of Operating Self-Funded Plans Will Increase**

Another negative effect of allowing state anti-subrogation laws to override ERISA's deemer provision is the increased complexity which will result from administering self-funded plans on a state-by-state basis. Since adoption of ERISA, such plans have been established and operated on a nationally uniform basis and free from state regulation. If subrogation clauses are invalidated, states will be encouraged to enact laws similar to the Pennsylvania anti-subrogation statute. Some states are likely to enact such statutes, while others will choose not to do so. Monitoring and compliance with varying and often inconsistent state statutes will create significant new administrative burdens. Instead of promoting order and greater uniformity, greater fragmentation and confusion will result.

Moreover, some states will feel emboldened to enact insurance laws and regulations which go beyond anti-subrogation laws and attempt to regulate a variety of subjects not deemed to be "core ERISA concerns."<sup>9</sup> Ultimately, employers and employees will bear the additional costs associated with such statutes.

#### **C. The Continued Viability of Self-Insurance As An Alternative Method of Providing Health Benefits Is Threatened**

It is a long-standing practice that certain risks, including the medical expenses of employees, can be financed by employers from their own current revenues. When such benefits are not insured, directly or indirectly, no insurance company is responsible for providing them. Indeed, even prior to ERISA, state courts understood that an employer who self-funds health benefits is not in the "insurance business." *Farmer v. Monsanto Co.*, 517 S.W.2d 129 (Mo. 1974).

Unlike conventional insurance where the risk of loss is *transferred* to an insurance carrier upon payment of a premium, self-insurance is generally understood to mean the *self assumption* (or retention) of one's own risk of a particular loss. As an integral part of a firm's risk management program, self-insurance can include the assumption of all or part of a firm's risk of loss for health benefits, property and casualty exposures and workers' compensation

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<sup>9</sup> For example, over 37 states have enacted insurance laws mandating over 700 special benefits. The treatment of alcoholism, mental illness and drug addiction are examples of such statutes—all of which may be characterized as not in conflict with "core ERISA concerns."

liabilities. Thus, employers seeking a cost-effective alternative to conventional insurance increasingly have adopted self-insured programs in managing various elements of risk related to the business enterprise.

Considerations which have stimulated the utilization of self-insurance for funding health benefits include direct control over claims settlements, greater flexibility to design and administer health plans to meet specific employee needs, cash flow advantages and freedom from state insurance regulation. For example, firms which pay for health benefits from general assets gain the financial advantage of the time-value of their capital assets. Since medical claims are paid as submitted, firm assets can be retained as working capital and invested. Thus, interest can be earned as funds that otherwise would be paid in the form of premiums for conventional insurance (which includes reserves) are retained by the employer. These unique characteristics and the favorable legal regulatory environment fostered by ERISA and the *Metropolitan Life* decision have contributed significantly to the dramatic expansion of self-insured health plans.

#### CONCLUSION

Inclusion of a broad preemption provision in ERISA was designed by Congress to displace state laws, primarily because of the increasingly interstate nature of employee benefit plans and the often conflicting state standards applicable to such plans. To limit the breadth of ERISA's deemer provision would close an important chapter in the development of ERISA's preemption policy and open a new chapter with significant adverse implications for employee

benefit plans. In sum, failure to reverse the Third Circuit's decision will open the door for state legislatures to enact statutes not deemed in conflict with core ERISA concerns which may even threaten the continuation of self-insurance as an attractive alternative for providing health benefits to millions of employees.

Respectfully submitted,

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IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1989

FMC CORPORATION,  
*Petitioner,*

v.

CYNTHIA ANN HOLLIDAY,  
*Respondent.*

On Writ of Certiorari to the United States  
Court of Appeals for the Third Circuit

**BRIEF OF THE TRAVELERS INSURANCE COMPANY  
AS AMICUS CURIAE IN SUPPORT OF PETITIONER**

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### **QUESTION PRESENTED**

Whether the Employee Retirement Income Security Act of 1974, as amended, pre-empts a State law insofar as it prohibits self-funded employee benefit plans from requiring plan beneficiaries to reimburse the plans for medical expenses paid on their behalf and later recovered by them as damages in tort cases involving motor vehicles?

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IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1989

No. 89-1048

FMC CORPORATION,

v. *Petitioner,*

CYNTHIA ANN HOLLIDAY,

*Respondent.*

On Writ of Certiorari to the United States  
Court of Appeals for the Third Circuit

**BRIEF OF THE TRAVELERS INSURANCE COMPANY  
AS AMICUS CURIAE IN SUPPORT OF PETITIONER**

**INTEREST OF AMICUS CURIAE**

The Travelers Insurance Company ("Travelers") and its affiliates provide services to uninsured employee welfare benefit plans covered by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"). Travelers receives and processes benefit claims; prepares administrative forms; prepares and distributes summary plan descriptions, plan documents, and other forms and disclosures required by ERISA; calculates funding requirements; makes cost estimates; assists in plan design; and prepares materials required by governmental agencies.

A significant number of the uninsured plans for which Travelers provides such services cover participants in more than one State. By permitting each State to con-

trol the terms and conditions of multi-state plans, the decision below will require similarly-situated participants to be treated differently according to their State of residence. This significantly disrupts the plans' abilities to estimate and project benefit costs, adds additional claims processing costs and benefit costs to the plans' funding burdens, increases total health care expenses, and conflicts with the Congressional objective of ensuring uniformity of regulation of uninsured ERISA plans.

For these reasons, the decision below adversely affects the plans of Travelers' customers and, thus, the business and operations of Travelers.\*

### SUMMARY OF ARGUMENT

The court of appeals rendered the pre-emption provisions of ERISA needlessly complex. It read into those provisions qualifications and limitations that cannot be supported by statutory language or congressional intent. It adopted, without explanation, an erroneous interpretation of ERISA's saving clause that makes pre-emption turn on the form of the State law, rather than its actual effect. The court compounded this error by misinterpreting the deemer clause, which the court found necessary to consider only because of its misreading of the saving clause.

#### A.

The court's critical mistake was its failure to recognize that under ERISA a State law dealing with several subjects is pre-empted *only* insofar as it "relates to" employee benefit plans. ERISA's "saving" clause rescues a State law that would otherwise be pre-empted if the law regulates insurance. But the portion of a law directed at self-funded plans cannot thereby be saved. Such plans are not insurance companies and States can-

\* Letters from the parties consenting to the filing of this Brief have been filed with the Clerk of this Court. See Sup. Ct. R. 37.3.

not treat them as such. To the extent that a State law regulates self-funded plans, ERISA therefore pre-empts it because, to that extent, the State is not regulating insurance.

Here, Pennsylvania's anti-subrogation law applied to both employee benefit plans and insurance companies. After concluding that the Pennsylvania statute would therefore be pre-empted as a law relating to ERISA plans, the court turned to the saving clause. In this regard, ERISA required the court to consider the Pennsylvania law only insofar as it applied to plans, which is all that would otherwise have been pre-empted.

Instead of doing so, the court treated the saving clause as embodying an all or nothing proposition—either the entire Pennsylvania anti-subrogation statute was pre-empted or the entire statute was saved. Without explanation, the court then interpreted the saving clause to mean that if the *principal* effect of a State law is on the insurance industry, the entire law—including the portion regulating ERISA plans—escapes pre-emption as a law regulating insurance. Pennsylvania's law, the court concluded, was therefore saved.

The court's interpretation of the saving clause is completely untenable. It makes pre-emption turn on how a State chooses to frame its legislation. If, for example, Pennsylvania enacted a separate statute barring only employee benefit plans from subrogating, ERISA would require the law to be struck down. Such a statute would clearly "relate to" plans covered by ERISA and could not be saved as a regulation of insurance since employee benefit plans are not insurance companies, even under Pennsylvania's definition.

That Pennsylvania combined, in one section, its subrogation ban against ERISA plans with a ban against insurance companies should lead to no different result. Both types of statutes equally frustrate Congress's goals. ERISA does not dictate what benefits plans must pro-



vide or what conditions plans may attach to those benefits. Congress decided that to do so as a matter of federal law would threaten its objective of encouraging employers to institute such plans voluntarily and to expand the coverage of existing plans. State laws, such as Pennsylvania's, pose precisely the same threat. By precluding plans from recovering medical expenses paid to employees, Pennsylvania has necessarily increased the costs of providing such coverage. Moreover, if Pennsylvania is permitted to regulate plans in this manner, multi-state plans will be subjected to a welter of different and potentially conflicting State laws, a burden ERISA's pre-emption provisions were designed to remove.

Under ERISA, it was therefore irrelevant that Pennsylvania imposed a mandatory and costly regulation on employee benefit plans in the same statute applying that regulation to the insurance industry. The court's conclusion that the principal effect of the Pennsylvania law was on insurance companies misses the crucial point—namely, that ERISA pre-empts a State law insofar as it governs employee benefit plans regardless whether that is the State law's primary objective, principal purpose or secondary effect.

The court's application of a test to determine whether the practice of subrogation constitutes the "business of insurance" was therefore wide of the mark. Pennsylvania's anti-subrogation law as applied to insurance companies was not threatened with pre-emption and did not have to be saved from that fate. The only aspect of the law challenged here dealt with employee benefit plans, not the business of insurance. The purpose of the saving clause—to preserve State authority over the insurance industry—was not implicated.

In short, the court of appeals failed to appreciate that, because ERISA pre-empts a State law only insofar as it relates to employee benefit plans, that is the only

aspect of the State law to be considered under the saving clause. Since the bar against plans like FMC's from seeking reimbursement for medical expenses was not saved as an insurance regulation, the Pennsylvania law as applied to employee benefit plans was pre-empted.

## B.

It was therefore unnecessary for the court of appeals to proceed to the third step of ERISA pre-emption analysis under the deemer clause, which provides that States may not deem employee benefit plans to be insurance companies in their laws regulating the insurance industry. The court's interpretation of the deemer clause was, in any event, wrong.

The court read the clause to mean that States may not regulate "core ERISA concerns" under the guise of insurance regulation. As the court saw it, core ERISA concerns were limited to reporting, disclosure and non-forfeiture. The language of the deemer clause obviously lends no support whatever to this interpretation. Moreover, the court's ruling resurrects limitations on pre-emption Congress specifically rejected. Earlier versions of ERISA limited pre-emption to the areas described by the court, but Congress decided that this was too restrictive and therefore, in the final version of the bill, significantly broadened its provisions.

The purpose of the deemer clause is to ensure that States cannot immunize their laws from pre-emption by defining employee benefit plans to be insurance companies. Giving effect to the plain meaning of the clause is sufficient to accomplish its purpose. The court's reluctance to do so was caused by its misinterpretation of the saving clause, which allowed State laws to escape pre-emption in their entirety despite the fact that they regulated plans. However, when the saving clause is properly interpreted along the lines discussed above, there is no reason for supposing that the deemer clause means anything other than what it actually says.

## ARGUMENT

### I. ERISA SHIELDS THE CONTENTS OF EMPLOYEE BENEFIT PLANS FROM STATE CONTROL

Employee welfare benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 88 Stat. 829, as amended, 29 U.S.C. §§ 1001 *et seq.* (1985 & 1989 Supp.), provide benefits to employees and their beneficiaries "for contingencies such as illness, accident, disability, death, or unemployment." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 n.5 (1983). Plans covered by ERISA may pay benefits directly from employer and/or employee contributions ("self-funding") or they may purchase insurance policies for their beneficiaries. FMC Corporation's ("FMC") plan is self-funded.

The FMC plan, *inter alia*, pays the medical expenses of company employees and their family members injured in motor vehicle accidents. *FMC Corp. v. Holliday*, 885 F.2d 79, 80 (3d Cir. 1989). As a condition to receiving these medical benefits, the beneficiary must agree to reimburse the plan if he or she later recovers medical expenses as damages in an action against the tortfeasor. *Id.* at 81. Through such provisions, plans are relieved of the financial burden caused by the fault of another and are able to control costs for the benefit of all participants. Without a reimbursement condition, employees who receive such recoveries in tort actions would be unjustly enriched at the plans' expense.<sup>1</sup>

State laws prohibiting reimbursement or subrogation in motor vehicle accident cases necessarily raise the cost

<sup>1</sup> In Pennsylvania, as in other States, plaintiffs in tort cases may recover damages for medical expenses incurred as a result of their injuries regardless whether they paid the expenses themselves. *Denardo v. Carneval*, 444 A.2d 135, 140 (Pa. Super. Ct. 1982) (Pennsylvania law clear that tort victim entitled to damages regardless of reimbursement from other sources); *Gallo v. Yamaha Motor Co.*, 526 A.2d 359, 367 n.13 (Pa. Super. Ct. 1987) (medical insurance does not negate tort recovery for medical expenses).

of coverage for these plans.<sup>2</sup> Barring self-funded plans like FMC's from being reimbursed for medical expenses requires the plans either to make up the losses through increased employer or employee contributions, or to drop or reduce their coverage of certain medical expenses. *See Liberty Mut. Ins. Group v. Iron Workers Health Fund*, 879 F.2d 1384, 1385 (6th Cir. 1989) (employee benefit plan excluded coverage of medical expenses resulting from automobile accidents).

To allow States to dictate plan terms in this manner not only would be contrary to the interests of the covered employees, but also would be at odds with one of the fundamental goals of ERISA. Employee benefit plans are not mandatory. Employers institute such plans on a voluntary basis. Through ERISA, Congress sought to encourage the formation of new plans and the expansion in coverage of existing plans. As Congress knew, these plans are costly undertakings for employers.<sup>3</sup> Con-

<sup>2</sup> In Pennsylvania, it was thought that subrogation in motor vehicle accident cases resulted simply in taking money "from one insurance company's pocket and putting it into another insurance company's pocket." *Pennsylvania Legis. J.*, 167th Sess. at 2171 (Dec. 13, 1983) (remarks of Rep. Manderino). Apparently, the hope was that by barring subrogation, litigation between insurance companies would be reduced, and that more insurance premium dollars would therefore be devoted to benefits rather than to processing claims.

Whatever might be said for this rationale, it does not apply to self-funded employee benefit plans such as FMC's. Such plans are not profit-making enterprises. Under ERISA Section 404(a)(1)(A), all plan assets, which include amounts collected through subrogation and reimbursement, must be used for the "exclusive purpose of providing benefits to participants and their beneficiaries . . . ."

<sup>3</sup> Much of the bill for health care in the United States is now paid by employer-sponsored plans. A recent survey indicates that "[b]usiness's share of the nation's doctor bill has grown to a staggering 45% of operating profits." Farnham, *No More Health Care on the House*, *Fortune*, Feb. 27, 1989, at 71. The cost of maintaining such plans is escalating even more rapidly than health



gress recognized that if federal law required particular benefits, this could defeat ERISA's goal.<sup>4</sup> The greater the cost, the more likely employers would respond by narrowing existing plans or refusing to establish new ones. See *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11-13 (1987). In ERISA, Congress therefore decided not to "mandate that employers provide any particular benefits" (*Shaw*, 463 U.S. at 91).

Congress did not intend the States to fill this void. Because State laws regulating the terms of voluntary plans could have the same counterproductive effect Congress

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care costs in general. In 1989, the cost of employer-provided health care rose by 20 percent, to an average of \$2,600 per employee. See *Health Care Keeps Taking Bigger Bites of the Economy*, BusinessWeek, Feb. 19, 1990, at 22. Employers facing these enormous expenses are naturally intent on keeping them under control. See Loomis, *The Killer Cost Stalking Business*, Fortune, Feb. 17, 1989, at 58. See generally *Employer-Sponsored Retiree Health Insurance: Hearing Before the Subcomm. on Oversight of the House Comm. on Ways and Means*, 100th Cong., 2d Sess. (1988).

<sup>4</sup> See, e.g., S. Rep. No. 383, 93d Cong., 1st Sess. 18 (1973):

Generally, it would appear that the wider or more comprehensive the coverage, vesting, and funding, the more desirable it is from the standpoint of national policy. However, since these plans are voluntary on the part of the employer and both the institution of new pension plans and increases in benefits depend upon employer willingness to participate or expand a plan, it is necessary to take into account additional costs from the standpoint of the employer. If employers respond to more comprehensive coverage, vesting and funding rules by decreasing benefits under existing plans or slowing the rate of formation of new plans, little if anything would be gained from the standpoint of securing broader use of employee pensions and related plans.

The same rationale underlies ERISA's regulation of employee welfare benefit plans. *Viggiano v. Shenango China Div. of Anchor Hocking Corp.*, 750 F.2d 276, 279 (3d Cir. 1984); *Musto v. American Gen. Corp.*, 861 F.2d 897, 912 (6th Cir. 1988), cert. denied, 109 S. Ct. 1745 (1989).

was determined to avoid, ERISA established "plan regulation as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981); see also *id.* at 511. Furthermore, if each State could decide for itself what an employee benefit plan must contain, multi-state plans would become subject to a welter of different and potentially conflicting requirements. See *Fort Halifax*, 482 U.S. at 11-13. The increased costs of instituting a plan in an anti-subrogation State, for example, could discourage multi-state employers from offering all of their employees the same plan regardless of the State of their employment. In that manner, the law of one particular State could unduly influence or control the terms of a plan that was regional in scope.<sup>5</sup>

## II. THE COURT OF APPEALS MISINTERPRETED ERISA'S SAVING CLAUSE

The Pennsylvania Motor Vehicle Financial Responsibility Law, enacted in 1984, 75 Pa. Cons. Stat. Ann. §§ 1701 *et seq.* (Purdon 1989 Supp.), requires insurers issuing liability insurance policies<sup>6</sup> covering motor vehicles to include, among other things, "a medical benefit in the amount of \$10,000 . . . ." § 1711. Insurers issuing

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<sup>5</sup> See, e.g., S. Rep. No. 127, 93d Cong., 1st Sess. 29 (1973) ("it is evident that the operations of employee benefit plans are increasingly interstate. The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws."); H.R. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973) (same); 120 Cong. Rec. 29,933 (remarks of Sen. Williams) (1974) ("It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.").

<sup>6</sup> Liability insurance indemnifies the insured for tort or statutory liability to third persons based on covered "occurrences" or accidents.



first party benefit policies<sup>7</sup> are also required to include, in each such policy, coverage of liability in the minimum amounts required by Section 1711. § 1715(c).

Automobile insurance policies issued under the Pennsylvania law are "primary" with respect to other payment sources, except worker's compensation. The injured person recovers from the automobile insurance company and, if the loss exceeds the policy's first party benefit limits, only then from "[a]ny program, group contract, or other arrangement" providing medical and other benefits. § 1719(a). Under Section 1720, however, there is "no right of subrogation or reimbursement from a claimant's tort recovery" in a motor vehicle accident case with respect to benefits payable from sources listed in Section 1719, the "coordination of benefits" provision.<sup>8</sup> As interpreted by the court of appeals, the phrase "other arrangement" in Section 1719(a), and consequently the anti-subrogation provision in Section 1720, applies to all

<sup>7</sup> First party benefits are paid to the insured without regard to whether the insured was at fault.

<sup>8</sup> At the time the case was decided Section 1720 provided that:

In actions arising out of the maintenance or use of a motor vehicle, *there shall be no right of subrogation or reimbursement from a claimant's tort recovery* with respect to workers' compensation benefits, benefits available under Section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or *benefits in lieu thereof paid or payable under section 1719 (relating to coordination of benefits)*. 75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1984 Supp.) [emphasis added].

This Section was amended on February 7, 1990, effective July 1, 1990, which changed the last clause to "or benefits paid or payable by a program, group contract or other agreement whether primary or excess under Section 1719 (relating to coordination of benefits)." 75 Pa. Cons. Stat. Ann. § 1720, as amended by Motor Vehicle Insurance, Pleadings, Operators of Commercial Vehicles, Act of Feb. 7, 1990, Pub. L. No. 11, § 1720, 1990 Pa. Legis. Serv. No. 1 (Purdon).

medical benefit plans regulated by ERISA. *FMC Corp.*, 885 F.2d at 82.

To decide whether the Pennsylvania law was pre-empted, Section 514(a) of ERISA required the court of appeals to determine first whether the State law "related to" employee benefit plans.<sup>9</sup> If it did, ERISA pre-empted the "law" unless it came within Section 514(b) (2) (A), which provides:

Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

If the State law were saved from pre-emption by Section 514(b) (2) (A), the court would then proceed to the third step of determining whether the law nevertheless fell under the "deemer" clause of Section 514(b) (2) (B).<sup>10</sup>

As we next discuss, after correctly holding that the Pennsylvania statute "related to" employee benefit plans, the court of appeals incorrectly determined that the law *as applied to such plans* came within the saving clause exception to pre-emption in Section 514(b) (2) (A). As a result of this error, the court found it necessary to proceed to the third step of pre-emption analysis under

<sup>9</sup> Section 514(a) provides:

Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

<sup>10</sup> The deemer clause provides:

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, . . . or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

ERISA. Here too the court erred by resurrecting under the deemer clause a pre-emption test Congress had specifically rejected when it revised these provisions in conference.

**A. As Applied to Plans Covered by ERISA, Pennsylvania's Anti-Subrogation Law Was Not Rescued from Pre-Emption by the Saving Clause**

Pennsylvania's anti-subrogation law, as interpreted by the court of appeals, plainly "relate[d] to an employee benefit plan" within the meaning of Section 514(a) of ERISA. *FMC Corp.*, 885 F.2d at 84. See *Shaw*, 463 U.S. at 96-97. The Pennsylvania statute directly regulated such plans, dictating the terms by which plans could provide medical benefits for participants involved in motor vehicle accidents. As a result, the reimbursement condition in the FMC plan was rendered unenforceable under State law.<sup>11</sup>

Neither Pennsylvania's Motor Vehicle Financial Responsibility Law nor the anti-subrogation provision in it were, however, threatened with pre-emption in their entirety. ERISA instead contemplates "pre-emption as applied." Section 514(a) thus invalidates State laws "only insofar as they relate to" employee benefit plans. *Shaw*,

<sup>11</sup> Unlike FMC's plan, some plans purchase insurance policies for their beneficiaries. It might be argued that Pennsylvania's anti-subrogation law also "related to" those plans. The point is, however, academic in light of *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), which holds that insurance policies purchased by plans are not immune from State laws generally regulating insurance companies.

On the other hand, *Metropolitan Life* makes clear that a State's regulation of self-funded plans raises a different issue regarding pre-emption. The Court noted that Massachusetts, which required certain insurance policies to contain mental health benefits, did not require self-funded plans to do so, "effectively conceding that [such] application . . . would be pre-empted by ERISA." 471 U.S. at 735-36 n.14.

463 U.S. at 85 n.17.<sup>12</sup> The point is critical when the saving clause of Section 514(b)(2)(A) is considered.

The saving clause represents a narrow exception to Section 514(a). It rescues some laws that would otherwise fall under Section 514(a) insofar as they apply to ERISA plans. To be saved, the law must constitute a regulation of insurance. Since Section 514(a) would preempt only the portion of a State law relating to plans, that portion of the law must regulate insurance in order to survive pre-emption.<sup>13</sup> Therefore, with respect to the Pennsylvania statute in this case, the question under the saving clause was whether the anti-subrogation provision as applied to employee benefit plans escaped pre-emption as a law regulating insurance. That, however, is a question the court of appeals never addressed.

Instead, the court embarked upon an entirely different inquiry. Without explanation, the court interpreted the saving clause to shield State laws in their entirety, regardless of their effect on employee benefit plans, so long as the "principal and substantial effect" of the law is "on the insurance industry." *FMC Corp.*, 885 F.2d at 86.<sup>14</sup> The court did not make clear whether, in finding

<sup>12</sup> In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), for example, Mississippi's common law of bad faith applied to contracts in general, including insurance contracts. The Court held that ERISA pre-empted Mississippi's law to the extent it governed employee benefit plans. The rest of Mississippi's law remained standing because it did not relate to ERISA plans.

<sup>13</sup> State laws relate to plans but nevertheless regulate insurance when they control the terms of insurance policies purchased by plans to cover participating employees. See note 11, *supra*.

<sup>14</sup> The court merely cited two other court of appeals decisions adopting, without explanation, a similar construction of Section 514(b)(2)(A). See *Northern Group Servs. v. Auto Owners Ins. Co.*, 833 F.2d 85, 89 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988) (Michigan's coordination of benefits law fell within the saving clause because it "is aimed principally at different types of insurance coverage.") (emphasis in original); *United Food &*



this "principal and substantial effect" test satisfied, it evaluated the Pennsylvania Motor Vehicle Financial Responsibility Law as a whole or only the section dealing with subrogation.<sup>15</sup> Neither did the court explain what factors a judge should consider in measuring the "effect" of a particular law. For their part, the parties simply agreed that the Pennsylvania law regulated insurance and devoted their arguments to the effect of Section 514 (b) (2) (B), the deemer clause. 885 F.2d at 85.

The court's interpretation of the saving clause is not correct. Pre-emption cannot depend upon whether the "principal and substantial effect" of a State's law is on insurance. To say that a State law primarily affects one thing is to concede that it also affects something else, here employee benefit plans. But State laws controlling plans do not escape pre-emption for that reason. It is of no importance that a State's regulation of ERISA plans is contained in a broad legislative package aimed at the

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*Commercial Workers v. Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986) (Arizona's anti-subrogation law was within the saving clause although it applied to both "insurance companies and private parties"). *Pacyga* held, however, that the Arizona law ran afoul of the deemer clause and was therefore pre-empted. 801 F.2d at 1161-62.

<sup>15</sup> The court seemed to be assessing Pennsylvania's Motor Vehicle Financial Responsibility Law in its entirety:

We agree that Pennsylvania's Financial Responsibility Law plainly "regulates insurance" within the meaning of the savings clause. 885 F.2d at 85-86.

Insofar as the Financial Responsibility Law expressly regulates insurance contracts, it necessarily falls within the ambit of the savings provision. *Id.* at 86.

... the Financial Responsibility Law "regulates insurance ... ." *Id.*

Only once in its analysis of the saving clause did the court specifically mention the anti-subrogation provision. *Id.* ("The statute's coordination of benefits and anti-subrogation provisions directly control the terms of insurance contracts.").

insurance industry.<sup>16</sup> Otherwise, the saving clause becomes dependent on how the State has framed its legislation rather than on the ERISA policies it was intended to implement.

To illustrate, suppose a State's anti-subrogation measure were directed at employee benefit plans *alone*. No one could have the slightest doubt that such a law would be pre-empted.<sup>17</sup> Even if the State added a second section dealing only with subrogation by insurance companies, the first section would still control employee benefit plans, and could not be saved from pre-emption as a law regulating insurance.

Yet there is only one distinction between the State law just hypothesized and Pennsylvania's anti-subrogation provision—namely, the Pennsylvania prohibition against insurance companies and employee benefit plans is contained in one statutory section rather than two. As far as ERISA is concerned, however, that is a distinction without a difference.<sup>18</sup> The effect on a plan's terms, its

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<sup>16</sup> See *Alessi*, 451 U.S. at 525 ("ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision.").

<sup>17</sup> A State law along the following lines, for example, would clearly be invalid: "an employee benefit plan shall have no right to be reimbursed by an employee to whom the plan has provided medical benefits when such employee has recovered medical expenses in a suit against the tortfeasor." Cf. *Mackey v. Lanier Collections Agency & Serv.*, 486 U.S. 825, 829-30 (1988). Such a law would plainly "relate to any employee benefit plan" within the meaning of Section 514(a) and could not be saved from pre-emption by Section 514(b) (2) (A) because it would not be a law "which regulates insurance." See pp. 17-18, *infra*.

<sup>18</sup> Invalidating Pennsylvania's statute as applied to employee benefit plans, as we suggest, may raise the question whether this portion of the State law is severable from the rest of the statute. This is solely a matter of State law. See, e.g., *Davis v. Michigan Dep't of Treasury*, 109 S. Ct. 1500, 1509 (1989); *Exxon Corp. v. Hunt*, 475 U.S. 355, 376 (1986). See also *Attorney General v. Travelers Ins. Co.*, 433 N.E.2d 1223, 1225 (Mass. 1982), the case



finances and its administration is identical. ERISA's goal of encouraging voluntary employer action is equally threatened in both situations. The danger of conflicting State regulation of multi-state plans is precisely the same. Regardless whether the State's legislation mainly deals with insurance or some other subject, when a State applies its law to plans covered by ERISA it is regulating those plans, not insurance companies.<sup>19</sup>

**B. Under the Saving Clause It Is Irrelevant That the Effect of Pennsylvania's Law Was Mainly on Insurance Companies**

The language and purpose of the saving clause do not support the lower court's construction. The clause sim-

underlying *Metropolitan Life*, in which the State court held that the provisions relating to the insurance industry, which were not pre-empted, were severable from the provisions pertaining directly to employee benefit plans, which all parties assumed were pre-empted.

Pennsylvania law provides that "[i]f any provision of any statute or the application thereof to any person or circumstance is held invalid, the remainder of the statute . . . shall not be affected thereby" unless the court finds that the remaining provisions are so "inseparably connected" with the void provision that the General Assembly would not have enacted the "remaining valid provisions," or unless the court finds that the "remaining valid provisions, standing alone, are incomplete and are incapable of being executed in accordance with the legislative intent." 1 Pa. Cons. Stat. Ann. § 1925 (Purdon 1989 Supp.) (emphasis added).

<sup>19</sup> See *Alessi*, 451 U.S. at 524, treating as immaterial the fact that a State statute's primary purpose was not to govern the terms of ERISA plans, when in fact the statute had that effect.

Section 514(c) defines "State law" to mean "all laws, decisions, rules, regulations, or other State action having the effect of law," and defines "State" to mean a State, its political subdivisions and agencies which "purport[] to regulate, *directly or indirectly*, the terms and conditions of" employee benefit plans (emphasis added). As *Alessi* holds, even if the State regulation is not directly aimed at employee benefit plans, it is pre-empted to the extent that such plans are swept within the scope of the State law.

ply provides that nothing in Section 514(a) shall relieve any person from the duty of complying with a State law regulating insurance. The purpose of the clause is to preserve the States' long-standing authority, reflected in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*, over the business of insurance. *Metropolitan Life*, 471 U.S. at 742. Congress anticipated that many plans, rather than being self-funded like FMC's, would purchase insurance. H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 292, 296 (1974). If the insurance policies purchased by those plans were not subject to State law, there could be a gap in regulation because ERISA does not itself control the business of insurance.<sup>20</sup>

But none of this leads to the conclusion that State laws dictating the contents of employee benefit plans are saved from pre-emption whenever they are contained in a statutory provision primarily aimed at the insurance industry. Plans covered by ERISA are not insurance companies nor are they engaged in the business of insurance,<sup>21</sup> and State laws regulating insurance cannot be applied to them. In-

<sup>20</sup> There is thus a distinction "between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not," but that is "a distinction created by Congress." *Metropolitan Life*, 471 U.S. at 747. See note 11, *supra*.

<sup>21</sup> Throughout ERISA, Congress clearly distinguished between plans, on the one hand, and insurance companies or insurance carriers, on the other. See, e.g., Sections 3(17) (definition of "separate account"); 103 (annual report requirements); 301 (defining insurance contract plan as, *inter alia*, plan with benefits guaranteed by an insurance carrier); 302(b)(5)(B)(iii)(II) (as amended) (interest rate for determining plan's current liability shall be consistent with assumptions that would be used by insurance companies); 401(b)(2)(A) (defining insurer in context of plan to which guaranteed benefit policy is issued by an insurer); 403(b) (establishment of trust requirement not applicable to assets of plan consisting of insurance policies issued by insurance company or to assets of such insurance company or plan assets held by such company); 408 (exemptions from prohibited transactions); 514(b)(2) (insurance savings clause and deemer clause).

deed, the Pennsylvania Attorney General so instructed the State's insurance commissioner shortly after ERISA was enacted.<sup>22</sup> Yet the court of appeals, by allowing the "principal effect" of State law to control, has obliterated the clear-cut distinction between plans and insurance, a distinction ERISA's pre-emption provisions were carefully designed to preserve.

In deciding that the Pennsylvania law mainly affected insurance, the court of appeals used a three-part test to determine whether the practice of subrogation constituted the "business of insurance." *FMC Corp.*, 885 F.2d at

<sup>22</sup> See Office of the Attorney General, *Minimum Premium Agreements and Administrative Service Plans*, Opinion No. 75-22 (June 30, 1975), 5 *Pennsylvania Bulletin* 1804, 1805 (July 5, 1975). After observing that the relationship between a self-funded plan and its participants is not one of seller and purchaser, with profits accruing to the seller, the Pennsylvania Attorney General concluded that self-funded plans "which assume part or all of the risk of indemnity to employees do not constitute the transaction of insurance business under Pennsylvania insurance laws and are not subject to regulation by the Insurance Department." The Attorney General further noted that ERISA:

specifically regulates employer-sponsored programs and exempts them from regulation under state insurance laws . . . .

Accordingly, where an employer assumes full responsibility for paying out benefits, the plan would be governed completely by [ERISA]. Where a minimum premium agreement is in operation, the employer's liability under its own plan would be regulated by [ERISA], but the premium agreement and any other contractual relationships between an employee benefit plan and an insurer would remain subject to regulation by state law . . . .

The foregoing Opinion, which the court of appeals did not mention, tends to call into doubt the court's holding that §§ 1719 and 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law were intended to apply to employee benefit plans. See *Northern Group Servs., Inc. v. State Farm Mut. Auto. Ins. Co.*, No. 89-1053 (6th Cir. Mar. 21, 1990) (also reported, LEXIS, Genfed. Library, 1990 U.S. App. LEXIS 3979).

86.<sup>23</sup> But that test, developed in case law under the McCarran-Ferguson Act, had no bearing on this case. There was no need to determine whether, as a general matter, subrogation in motor vehicle accident cases was part of the insurance business. Even if it were—and there is room for disagreement about the issue<sup>24</sup>—

<sup>23</sup> The test is:

*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

*Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (emphasis in original), quoted in *Pilot Life*, 481 U.S. at 49, and *Metropolitan Life*, 471 U.S. at 743.

<sup>24</sup> There is a split in the circuits about whether, under this three-part test, an anti-subrogation law regulates the business of insurance. The Ninth Circuit agrees with the court below. *Pacyga*, 801 F.2d at 1161. (*Pacyga* held that Arizona's anti-subrogation law, although within the saving clause, was pre-empted by the deemer clause. *Id.* at 1161-62.)

On the other hand, the Eighth Circuit has held that a State's common law rule against subrogation was not saved from pre-emption under Section 514(b)(2)(A) in light of the fact that "subrogation does not transfer the risk from a policyholder to his or her insurer." *Baxter v. Lynn*, 886 F.2d 182, 186 (8th Cir. 1989). This appears correct. With respect to the Pennsylvania law, the provider of benefits is merely engaging in the practice of seeking reimbursement for expenses already paid on the injured party's behalf. It is not changing the risk allocation between the plan or insurer and the injured party.

In addition, the anti-subrogation law in *Baxter* and the Pennsylvania law in this case fail to satisfy part three of the test because neither the practice of subrogation nor the laws outlawing it are "limited to entities within the insurance industry." *Pireno*, 458 U.S. at 129, quoted in *Pilot Life*, 481 U.S. at 49, and *Metropolitan Life*, 471 U.S. at 743.

As discussed in the text, however, we do not believe this test has any bearing on the question presented in this case.



ERISA posed no threat to Pennsylvania's ban on the practice by insurance companies. The question here was whether application of the same restriction to employee benefit plans could escape pre-emption. Because a law barring plans from subrogating does not regulate insurance, the answer was clear—ERISA pre-empted Pennsylvania's anti-subrogation provision insofar as it applied to plans.

### III. THE COURT OF APPEALS MISCONSTRUED THE DEEMER CLAUSE

Because Section 514(b)(2)(A) did not save the Pennsylvania statute insofar as it regulated employee benefit plans, that should have been the end of the matter. Having misconstrued the saving clause, however, the court of appeals found it necessary to consider the effect of Section 514(b)(2)(B), the deemer clause, which provides:

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, . . . or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

The clause is unambiguous. While the saving clause preserves the States' authority to regulate insurance even when employee benefit plans are thereby affected, the deemer clause assures that the States will not abuse this authority by defining plans covered by ERISA as insurance companies or as entities engaged in the business of insurance.<sup>25</sup>

<sup>25</sup> For example, if Pennsylvania had barred only insurance companies from subrogating in motor vehicle accident cases, and then defined "insurance companies" to include employee benefit plans, the deemer clause would prevent the law from avoiding pre-emption insofar as it dealt with such plans.

The court of appeals, however, thought that "the deemer clause is meant mainly to reach back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation." 885 F.2d at 86. "Core ERISA concerns" were, in the court's view, "reporting, disclosure and nonforfeitability." *Id.* at 88. The consequence of the court's ruling is that the States are free to regulate all other aspects of employee benefit plans so long as they do so in a law primarily regulating insurance.

Why Congress would have intended to permit such broad State authority over employee benefit plans is difficult to understand. Still less is it apparent how the language of the deemer clause can support the court's notion that States may define employee benefit plans as insurance companies in "non-core" areas but not in areas at the "core" of ERISA. The clause itself contains no such qualifications. It provides, without exception, that such plans cannot be considered insurance companies under State laws regulating insurance.

To make matters worse, the court of appeals based its reading of the deemer clause on legislative proposals Congress expressly rejected. One of the last versions of ERISA's pre-emption provision, for example, would have specifically superseded all state laws "as they may now or hereafter relate to the reporting and disclosure responsibilities, and fiduciary responsibilities, of persons acting on behalf of any employee benefit plan to which part 1 applies." *Id.* at 87, quoting from "2 Legislative History of the Employee Retirement Income Security Act of 1974 at 2920-22." In light of this history, the court thought that the deemer clause, as enacted, "was meant to do the more narrow, specified work which the original version of the preemption clause was meant to do." 885 F.2d at 88. In further support of its conclusion, the court relied



on the following remarks of Senator Javits, supporting the final version:

In view of Federal preemption, State laws compelling disclosure from private welfare or pension plans . . . unless a criminal statute of general application . . . will be superseded.

120 Cong. Rec. 29,942 (1974), cited by the court below, 885 F.2d at 88.

The court is clearly mistaken. The earlier versions of ERISA's pre-emption clauses were considerably narrower than those enacted. Congress made a deliberate choice to abandon those limited proposals in favor of broad pre-emption. As the Court explained in *Shaw*, 463 U.S. at 98, the "bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected these provisions in favor of the present language, and indicated that the section's pre-emptive scope was as broad as its language."

By reading back into the deemer clause the limitations Congress rejected, the court below violated one of the cardinal principles of statutory interpretation. As the Court held in *INS v. Cardoza-Fonseca*, 480 U.S. 421, 442-43 (1987), "[f]ew principles of statutory construction are more compelling than the proposition that Congress does not intend *sub silentio* to enact statutory language that it has earlier discarded in favor of other language." *Nachman v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 392-93 (1980) (Stewart, J., dissenting)." Moreover, Senator Javits' remarks, quoted by the court, do not have the significance the court attributed to them. Senator Javits merely gave an example of a State law that would be pre-empted under the bill as enacted. That the same law would have been pre-empted under the earlier version is hardly surprising in light of the fact that Congress

deliberately made the final pre-emption section much broader in scope. By no means can Senator Javits' remarks support the court's conclusion that Congress intended to limit the final provision to the narrower scope of the discarded version.

The court of appeals offered another rationale for its interpretation of the deemer clause:

Any reading other than one confined to the central aspects of ERISA would either have the deemer clause swallow the savings clause or read into the statute other distinctions that are not there.

885 F.2d at 88. Apparently the court thought that it would be senseless for the deemer clause to strike down all laws regulating both insurance companies and employee benefit plans when the saving clause rescues those laws in their entirety.

But the problem the court identified was of its own making. If the court had correctly interpreted the saving clause, the Pennsylvania statute would have been pre-empted insofar as it applied to self-funded ERISA plans. The court would then not have felt constrained to read into the deemer clause "distinctions that are not there," as it did. *Id.* The deemer clause simply prevents States from shielding their laws by deeming employee benefit plans to be insurance companies. The plain meaning of the clause, together with a proper interpretation of the saving clause, fully accomplishes Congress's objectives of immunizing self-funded plans from State regulation while preserving the States' traditional authority over the insurance industry.

**CONCLUSION**

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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IN THE

**Supreme Court of the United States**

OCTOBER TERM, 1989

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v.

**CYNTHIA ANN HOLLIDAY,**

*Respondent.*

On Writ of Certiorari to the United States  
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**BRIEF OF THE CENTRAL STATES, SOUTHEAST AND  
SOUTHWEST AREAS HEALTH AND WELFARE FUND AS  
AN AMICUS CURIAE IN SUPPORT OF PETITIONER**

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No. 89 - 1048

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**CYNTHIA ANN HOLLIDAY,***Respondent.*

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**On Writ of Certiorari to the United States  
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**BRIEF OF THE CENTRAL STATES, SOUTHEAST AND  
SOUTHWEST AREAS HEALTH AND WELFARE FUND AS  
AN AMICUS CURIAE IN SUPPORT OF PETITIONER**

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## THE INTEREST OF THE AMICUS CURIAE

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The Central States, Southeast and Southwest Areas Health and Welfare Fund ("Fund") is a Taft-Hartley trust and an employee welfare benefit plan as described in Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1002(1).<sup>1</sup> *See Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 561-562 (1985). The Fund self-funds all medical, hospital and disability benefits that it provides to its more than 500,000 participants and beneficiaries. These participants and beneficiaries reside in over thirty-four states of the United States.

Due to escalating medical care costs and limited income in the form of fixed employer contributions, the Trustees of the Fund have included cost-containment measures, such as subrogation and coordination of benefits provisions, in the plan pursuant to their fiduciary duties under ERISA to manage plan assets prudently and in the best interest of all participants and beneficiaries. *See* 29 U.S.C. §1104(a)(1)(B). The Fund is significantly and adversely affected by the ruling in this case by the United States Court of Appeals for the Third Circuit because the Fund does provide benefits to participants and beneficiaries who reside in Pennsylvania. Due to the Third Circuit's opinion in this case, the Fund probably will not be able to enforce its subrogation provision in Pennsylvania and thus will be deprived of an important cost-containment meas-

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<sup>1</sup> Both the petitioner, FMC Corporation, and the respondent, Cynthia Ann Holliday, gave the Fund consent to file this *amicus curiae* brief, and copies of their attorneys' letters confirming this consent have been sent with this brief to the Clerk of the United States Supreme Court.

ure. Moreover, the Fund will have to adopt different administrative procedures to comply with this Pennsylvania insurance law, thereby causing the Fund to incur another financial cost and administrative burden.

The Fund is also adversely affected by the increasing disregard of the scope of ERISA preemption as demonstrated by the decision in this case and the decision of the United States Court of Appeals for the Sixth Circuit in the case of *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988). Both circuits have advanced equally vague tests for ERISA preemption which subordinate Congress' objective in including a broad preemption provision in ERISA, which is uniform, federal regulation of employee benefit plans, to state regulation of insurance. If this precedent is not corrected by this Court, the Fund, like thousands of other multi-state employee welfare benefit plans, will have to comply with conflicting and inconsistent state laws, many of which will require such plans to duplicate benefits or assume the financial burden of specific risk insurance coverage from specific risk insurers. These plans will also be forced to engage in substantial and widespread litigation due to the vagueness of these preemption tests.

Such precedents will encourage other states to adopt laws regulating employee benefit plans. The resulting patchwork scheme of federal and state regulation of self-funded employee welfare benefit plans will force these plans to reduce substantially their benefit levels. Accordingly, the Fund urges this Court to reverse the Third Circuit and to hold that ERISA preempts all state laws that relate to self-funded employee welfare benefit plans, including state insurance laws.

## SUMMARY OF THE ARGUMENT

The Fund urges this Court to reverse the holding of the United States Court of Appeals for the Third Circuit in this case for several reasons. First, the Third Circuit's interpretation of the deemer clause of Section 514 of ERISA directly conflicts with the plain meaning and legislative history of Section 514 and with several of this Court's decisions. By advancing a new test for ERISA pre-emption which states that the deemer clause allows preemption of state insurance law only where the state law conflicts with a "core ERISA concern," the Third Circuit is undermining the clear and expressed purpose and intent of Congress in including a broad preemption provision in ERISA which was to prevent patchwork regulation of self-funded employee benefit plans by the states. Moreover, the Third Circuit's holding directly conflicts with the decisions of this Court in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). Contrary to the Third Circuit's ruling, this Court in *Shaw* held that ERISA preemption is not limited to state laws that deal only with the subject matters covered by ERISA. 463 U.S. at 98. Moreover, the Third Circuit's holding violates the distinction mandated by Congress and recognized by this Court in the *Metropolitan Life* case, wherein this Court stated that insured employee benefit plans are subject to indirect state regulation while self-funded plans are not. 471 U.S. at 747.

This decision should also be reversed because the decision of the Third Circuit further splits the United States Courts of Appeal on the issue of the scope of ERISA preemption for self-funded employee benefit plans. Both

the Third Circuit in this case and the Sixth Circuit in the case of *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988), have advanced different but equally vague and insupportable tests for ERISA preemption. The Third and Sixth Circuits' restrictive interpretations of Section 514 conflict with the interpretations given by the Eighth, Seventh, Ninth, Fourth and Fifth Circuits.

The Third Circuit's decision also creates serious public policy problems. It effectively prohibits self-funded employee benefit plans from enforcing plan cost-containment measures that are critical to such plans. As a result of escalating medical care costs and the limited financial resources of such plans, many such plans have adopted subrogation and coordination of benefits provisions as cost-containment measures. If such plans are precluded from utilizing these cost-containment measures, comparable reductions in benefit levels will, at a minimum, have to occur.

Moreover, the vague tests advanced by the Third and Sixth Circuits for determining whether ERISA preempts a particular state law have caused and will continue to cause extensive and expensive litigation which employee benefit plans can little afford. If the precedents set by Third and Sixth Circuits are upheld by this Court, multi-state employee benefit plans will incur the substantial and potentially crippling administrative and financial costs of having to adopt separate plans and administrative procedures for each state in which their participants and beneficiaries reside. Therefore, the Fund recommends that this Court reverse the decision of the Third Circuit and uphold broad preemption under ERISA of state law relating to self-funded employee benefit plans.

## ARGUMENT

### I.

#### THE PREEMPTION TEST ADVANCED BY THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT SEVERELY LIMITS THE SCOPE OF ERISA PREEMPTION IN VIOLATION OF THE PLAIN MEANING AND LEGISLATIVE HISTORY OF SECTION 514 OF ERISA AND THIS COURT'S DECISIONS.

The Third Circuit's decision in the instant case directly conflicts with the plain meaning and legislative history of Section 514 of ERISA and with several of this Court's decisions which construe Section 514 of ERISA. In the instant case, the Third Circuit presented a new test for ERISA preemption, allowing preemption of a state insurance law only where the state law conflicts with a "core ERISA concern." *FMC Corp. v. Holliday*, 885 F.2d 79, 86, 89-90, *reh'g denied*, \_\_\_ F.2d \_\_\_ (3rd Cir. 1989), *cert. granted*, \_\_\_ U.S. \_\_\_, 110 S.Ct. 1109 (1990). To justify adoption of this "core conflict test," which subordinates Congress' goal to establish uniform, comprehensive federal regulation of employee benefit plans to the states' power to regulate insurance, the Third Circuit advances an insupportable interpretation of the deemer clause in Section 514, selectively cites legislative history out of context and criticizes a prior ruling by this Court. As to the distinction drawn between preemption as applied to self-funded employee benefit plans and insured employee benefit plans articulated by this Court in the *Metropolitan Life* case, the Third Circuit states that it lacks statutory and legislative history foundation. *Id.* at 86-89. The Third Circuit's decision also constitutes a direct conflict with this Court's holding that ERISA preemption is not limited to state laws that deal



with the subject matters covered by ERISA. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 98.

In construing the meaning of a statute, the starting point of such an analysis is the language of the statute, and unless an ambiguity in the language exists, this analysis should end without resorting to an analysis of the legislative history underlying the statute. See *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. —, 109 S.Ct. 1026, 1030, 103 L.Ed.2d 290 (1989). In the instant case, the Third Circuit does not identify any ambiguity in the deemer clause. Instead, it attempts to justify its selective review and strained analysis of the legislative history underlying the deemer clause by stating that the deemer clause's "scope is unclear." 885 F.2d at 84. The Third Circuit then concludes that ". . . the deemer clause guards against any insurance regulation that infringes on such ERISA areas as reporting, disclosure and non-forfeitureability." *Id.*

The Third Circuit's analysis and conclusion are erroneous for several reasons. First, there is no ambiguity in the deemer clause. This Court has held that the plain meaning of the deemer clause is unambiguous: "The deemer clause makes clear that a state law that 'purport[s] to regulate insurance' cannot deem an employee benefit plan to be an insurance company." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987). Thus, the deemer clause is the specified exception to the savings clause, which preserves state insurance and other laws from ERISA preemption, and the deemer clause prohibits employee benefit plans from being regulated by ". . . any law of any State purporting to regulate insurance companies, insurance contracts. . . ." 29 U.S.C. §1144(b)(2)(B). See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 733 (1985). Moreover, this Court has emphasized that, in construing

Section 514 of ERISA, the plain language must be enforced unless there is a good reason to believe Congress intended a more restrictive meaning to apply. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 97.

The Third Circuit's analysis of the deemer clause also fails due to its highly selective and biased review of the legislative history underlying Section 514 of ERISA. In examining the legislative history, the Third Circuit maintains that preemption under the deemer clause is basically limited to state laws that constitute ". . . back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation." 885 F.2d at 86, cited in, *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 91-94 (6th Cir. 1987), cert. denied, 486 U.S. 1017 (1988). To support this argument, the Third Circuit selectively quotes comments of ERISA legislative sponsors which relate only to their concern with state laws being "hastily contrived" to regulate ERISA plans. However, the very quotations utilized by the Third Circuit serve to underscore Congress' primary concern in including a broad preemption provision in ERISA, which was that employee benefit plans be subject to uniform federal regulation. The Senator Javits quotation, that ERISA preemption extended to "[s]tate laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme," clearly expresses his concern with the states' passing laws after ERISA's enactment to regulate areas of plan administration and operation not specifically governed by ERISA. 885 F.2d at 87. Senator Williams' statement also stressed Congress' concern that state professional regulations ". . . should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized." *Id.*

Uniform federal regulation of employee welfare and pension benefit plans was one of the fundamental and overriding purposes of Congress in enacting ERISA. So as to remove any doubt concerning the purposes that ERISA was to serve, Congress set forth its findings and declaration of policy in Section 2 of ERISA, which, in part, provides:

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations;

\* \* \* \* \*

29 U.S.C. §1001(a).

Moreover, ERISA's legislative sponsors stressed the importance of uniform federal regulation of employee benefit plans. In quoting Senator Williams, the Third Circuit ignores his explanation of the scope of ERISA preemption:

It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

*Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 99, quoting 120 Cong. Rec. 29933.

The Third Circuit also selectively cites Senator Javits' remarks, which continued after the statement quoted by the Third Circuit: "Although the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs." *Id.* at 99-100 n.20. As to the task force report denigrated by the Third Circuit, it was Senator Javits who explained that the members of the conference responsible for the final draft of ERISA had assigned the Congressional Pension Task Force with the responsibility of studying and evaluating ERISA preemption to determine what modifications in preemption policy would be necessary. *Id.* Another ERISA sponsor, Representative Dent, who was not quoted by the Third Circuit, also stressed the breadth of ERISA preemption:

Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

*Id.* at 99.

In examining the proposed house and senate bills and the conference bill ultimately passed by Congress, the Third Circuit does not grasp the significance of Congress' rejection of the bills which would have preempted only state laws affecting subjects specifically addressed in ERISA. By attempting to construe the word "purporting" in the deemer clause as the basis for limiting preemption to subject areas specifically regulated by ERISA, the



Third Circuit ignores the touchstone of Congress' expressed concern in incorporating a broad preemption provision in ERISA, *i.e.*, the establishment of uniform federal regulation of employee benefit plans. Moreover, its interpretation of the deemer clause would effectively incorporate the very language rejected by the Congress.

Based upon a thorough examination of the legislative history underlying Section 514 of ERISA, this Court has repeatedly held that ERISA preemption cannot be limited to only those state laws which regulate the matters covered by ERISA, including reporting, disclosure and fiduciary responsibility. 463 U.S. at 98. On the contrary, this Court has held that Section 514 was intended "... to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA's substantive requirements." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 739. As this Court has repeatedly explained, Congress considered and rejected bills which allowed preemption of only subject matters expressly governed by ERISA and which did not include a deemer clause reserving regulation of ERISA plans to the federal government. 463 U.S. at 98; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 46. These bills were rejected not only because they would have required ERISA plans to comply with multiple and potentially conflicting state laws, but also because they raise the possibility of "endless litigation" on issues of whether state regulation impinged upon federal regulation. 463 U.S. at 99 n.20. Moreover, after a period of monitoring by the Congressional Pension Task Force and hearings by a House Subcommittee, a report evaluating ERISA's preemption provisions was issued, and it stated that "the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded." *Id.* at 100 n.20, quoting H.R. Rep. No. 94-1785, p. 47 (1977).

Despite this clear authority supporting the wide scope of ERISA preemption, the Third Circuit further contends that any interpretation of the deemer clause other than that it prohibits insurance regulation of the "central aspects of ERISA" would render the savings clause meaningless or read in distinctions that are not supported by the statute. 885 F.2d at 88. Although the Third Circuit does not explain how any other interpretation of the deemer clause would "swallow" the savings clause, it criticizes this Court's interpretation of the savings and deemer clauses in the *Metropolitan Life* case, wherein this Court stated that insured plans are subject to indirect state regulation while self-funded employee benefit plans are not. *Id.* at 89. The Third Circuit implies that this Court erroneously created this distinction between self-funded and insured plans without reliance upon statutory language or legislative history, but instead based this distinction upon the "vague language in Congress' *post hoc* study." *Id.* at 89.

Again, the Third Circuit ignores the statutory language and legislative history of Section 514 of ERISA. The deemer clause prevents an employee benefit plan from being deemed an insurance company or other insurer or as being engaged in the business of insurance "... for purposes of any law of any State purporting to regulate insurance companies, insurance contracts. . . ." 29 U.S.C. §1144(b)(2)(B). However, the deemer clause does not preempt state laws regulating insurance contracts purchased by an employee benefit plan. The regulation of the content of insurance contracts is not subject to preemption due to the plain meaning of the savings clause. Thus, if an employee benefit plan chooses to self-fund its benefits, it cannot be deemed an insurance company which companies must under the laws of most, if not all, states submit their benefit plan provisions concerning eligibility,



benefit levels and terms and conditions for receiving benefits to the state department of insurance for review and approval as to their compliance with the state insurance code and other regulations. See *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. at 727-728. On the other hand, those plans which decide to purchase insurance coverage for their members from insurance companies must comply with the state law limitations placed on those insurance contracts. This indirect regulation of insured plans is thus expressly sanctioned by Congress. Moreover, the fact that plans may choose to self-fund benefits, and thus be entitled to adopt benefit rules without regard to state law, or to purchase insurance policies subject to state law restrictions comports with both the statutory provisions of ERISA's entrusting plan fiduciaries with exclusive authority to manage and control plan assets and with the legislative history which establishes that plan fiduciaries have broad discretion in determining how the plan is to be administered. See 29 U.S.C. §§1102(a)(1), 1103(a).

The Third Circuit takes an alternative position that its proposed test concerning the application of the deemer clause would not eradicate the distinction drawn by this Court between insured and self-funded employee benefit plans. 885 F.2d at 89. The Third Circuit explains that "... under *Metropolitan Life* insured plans would *per se* survive the deemer clause, while self-insured plans would merely be considered on a case-by-case basis as to whether the state regulation involved affects a central concern of ERISA." *Id.*

The Third Circuit's contention that its proposed test is actually in compliance with the Court's guidelines in *Metropolitan Life* lacks merit. The Third Circuit does not identify any statutory, legislative history or Supreme

Court case law authority for interpreting the deemer clause so as to limit preemption to those state laws which affect a "central concern" of ERISA. Furthermore, the Third Circuit does not define what constitutes a "central concern" of ERISA. Acknowledging the vagueness of its test, the Third Circuit admits that ERISA preemption of state law as applied to self-funded employee benefit plans will have to be decided on a case-by-case basis. This result was exactly what Congress expressly sought to preclude by adopting a broad preemption provision.

Because the Third Circuit rejects uniformity of regulation of employee benefit plans as a "central concern" of ERISA, it is apparent that the Third Circuit is suggesting a highly restrictive definition of "central concern" of ERISA. Thus under the Third Circuit's test, multi-state plans which, as this Court has recognized, already have the task of coordinating complex administrative activities will also have to endure the considerable inefficiencies, administrative burdens and financial costs of complying with a patchwork scheme of regulation. See *Fort Halifax Packing Co. v. Coyne*, 482 U.S. at 11. Such a result cannot be allowed to stand under the plain meaning and legislative history of Section 514 and the decisions of this Court.

## II.

### **IF THE DECISION OF THE THIRD CIRCUIT IS NOT REVERSED AND THE SCOPE OF ERISA PREEMPTION MAINTAINED AT ITS BROAD LEVEL, SIGNIFICANT AND ADVERSE PUBLIC POLICY PROBLEMS WILL RESULT.**

The conflicts among the circuits concerning the issue of the scope of ERISA preemption as to self-funded employee benefit plans is thoroughly discussed by FMC Corporation in its brief. To avoid repetition, the Central

States, Southeast and Southwest Areas Health and Welfare Fund ("Fund") will concentrate on the adverse public policy problems that will result unless this split among the circuits is resolved by reversing the Third Circuit and allowing broad preemption of state laws relating to employee benefit plans.

The problem of rising medical care costs for self-funded employee benefit plans cannot be overstated. For every year since 1965, inflation in medical care prices has been higher than the general rate of inflation for the economy on a whole.<sup>2</sup> In 1987, the price of health care in this country exceeded \$500 billion, increasing 9.8 percent from 1986.<sup>3</sup> In 1988, total health care expenditures rose 10.2 percent from 1987 to an estimated \$558.7 billion or about \$2,200.00 per capita.<sup>4</sup> Total health care expenditures for 1989 are expected to rise to approximately \$618.4 billion.<sup>5</sup> If health care trends continue, medical care costs could triple to \$1.5 trillion by the year 2000.<sup>6</sup>

In 1988, employers with insured programs experienced an average increase in health plan costs of 13.7 percent; whereas, self-funded plans experienced an average in-

<sup>2</sup> Sharkey & Buckle, *The Medicare Prospective Payment System: Impact On The Frail Elderly and An Alternative Reimbursement Formula*, 3 Notre Dame J. of L., Ethics & Pub. Pol'y 227, 228 (1988).

<sup>3</sup> Letsch, Levit & Waldo, *National Health Expenditures, 1987*, 10 Health Care Fin. Rev. 109 (Winter 1988).

<sup>4</sup> Francis, *U.S. Industrial Outlook 1989: Health Services*, Med. Benefits, Feb. 15, 1989, at 1.

<sup>5</sup> *Id.* at 2.

<sup>6</sup> *Costs Will Rise into the 1990s, Pushing Up Corporations' Benefits Costs*, 16 Pens. Rep. (BNA) 1979 (November 20, 1989).

crease of 24.8 percent in health plan costs for 1988.<sup>7</sup> In one survey of 2,000 employers who either purchased insurance coverage or self-funded health benefits, total health care costs equaled 37.2 percent of those employers' profits.<sup>8</sup>

As a result of these substantial and escalating costs of providing medical care, employee benefit plans throughout the country have had to reduce benefits, institute cost-containment measures, establish cost-management programs or a combination of the above. In compliance with their fiduciary duties under ERISA to manage plan assets prudently and in the best interest of all participants and beneficiaries, the Trustees of the Fund have included cost-containment measures in the plan, including subrogation and coordination of benefits provisions. See 29 U.S.C. §1104(a)(1)(B). The Trustees determined that these cost-containment measures are necessary to preserve plan assets for the payment of current and future medical benefits and to eliminate duplication of benefits with other insurance or plan coverages. The Fund's Trustees included these subrogation and coordination provisions as part of the plan terms in compliance with their fiduciary duties to manage the plan assets "... solely in the interest of the participants and beneficiaries ..." and, in managing these assets, to exercise "... the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." 29 U.S.C. §1104(a)(1)(B).

<sup>7</sup> A. Foster Higgins & Co., *Health Care Benefits Survey, 1988*, Med. Benefits, Feb. 28, 1989, at 1. See also, *Average Costs Rose 18.6 Percent Under Employer Plans, Survey Finds*, 16 Pens. Rep. (BNA) 250 (Feb. 13, 1989). This survey covered 1,600 employers and 10 million employees and dependents.

<sup>8</sup> DiBlase, *Group Health Bills Equal A Third of Profits*, Bus. Ins., May 29, 1989, at 1.



Multiemployer benefit plans, such as the Fund, are particularly affected by substantial increases in medical care costs because their income is primarily, if not solely, from employer contributions. The amount of each employer's contribution is fixed by collective bargaining agreements negotiated by the union and employers every three to five years. Depending upon how much of the collectively bargained moneys are allocated to wages, pension benefits and health benefits, there may not be sufficient funds to maintain health benefit levels. If the employers' contributions are not sufficient to fund plan benefits, the trustees of such plans have limited choices, namely to reduce benefit levels and/or to institute cost-containment measures.

Although most cost-containment measures and benefit reductions involve a transfer of costs to the participants and beneficiaries or a restriction in the type or length of medical care, two cost-containment measures, subrogation and coordination of benefits, do not. On the contrary, subrogation and coordination of benefits provisions prevent the duplication of benefits by the plan where other coverage exists and covers the particular injury or illness. Subrogation and coordination provisions also ensure that primary responsibility for providing benefits for specific risk injuries is not transferred from specific risk insurers, such as motor vehicle insurers, to employee benefit plans.

The Fund's Plan Document provides for subrogation against any person or entity responsible for providing a recovery to a Fund participant or beneficiary for injuries sustained as a result of an accident or illness. The Fund's coordination provision provides that where no-fault or personal injury protection ("PIP") motor vehicle insurance coverage exists, the no-fault or PIP coverage shall be primarily responsible for providing benefits to a mutually covered beneficiary who has sustained injuries as a result

of a motor vehicle accident and the Fund shall provide excess coverage. These subrogation and coordination provisions provide substantial cost-savings to the Fund, allowing it to cover rising medical costs without having to enact comparable benefit cuts or restrictions.

The application of state laws to prohibit the Fund from enforcing its subrogation and coordination provisions would deprive the Fund of very valuable and necessary cost-containment measures. If this were to occur, the Trustees would be limited primarily to changes in the benefit plan design that transfer the rising costs of medical care to the Fund's participants and beneficiaries, *e.g.*, lower percentage of coverage and higher deductibles, or that restrict their medical care options.

Currently, there are two circuit court decisions which limit the scope of ERISA preemption as applied to employee welfare benefit plans. In addition to the Third Circuit's decision, the United States Court of Appeals for the Sixth Circuit in the case of *Northern Group Services, Inc. v. Auto Owners Ins., Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988), also propounded a new test subordinating the Congressional goal of uniform federal regulation of employee benefit plans to the state's interest in regulating insurance. In *Northern Group*, the Sixth Circuit held that Section 500.3109a of the Michigan No-Fault Insurance Act, which authorizes motor vehicle insurance companies and their insureds to subordinate motor vehicle no-fault benefits to benefits provided by "other health and accident coverage," was not preempted by ERISA because of the priority of the state's power to regulate insurance. 833 F.2d at 94-95. To justify this holding, the Sixth Circuit advanced a new test for ERISA preemption, requiring that if a self-funded employee benefit plan is to avoid state regulation, it must first demon-



strate a federal interest in national uniformity *independent of and beyond* the requirements of Section 514 of ERISA, and that this specific federal interest must then “. . . outweigh the McCarran-Ferguson interest in state regulation of insurance.” *Id.* at 95.

State laws such as Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law and Section 500.3109a of the Michigan No-Fault Insurance Act effectively usurp the Trustees’ exclusive authority and responsibility under ERISA to control and manage plan assets in the best interest of all participants and beneficiaries. *See* 29 U.S.C. §1102(a)(1) (the plan must be administered pursuant to a written instrument and named plan fiduciaries have authority “. . . to control and manage the operation and administration of the plan.”); 29 U.S.C. §1103(a) (“. . . the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan . . .” except for certain circumstances not applicable to this case); 29 U.S.C. §1104(a)(1)(D) (plan fiduciaries are required to perform their duties solely in the interest of all participants and beneficiaries in accordance with the provisions of the plan document).

There are a substantial number of state laws either prohibiting or restricting subrogation and coordination in the contexts where the Fund utilizes these cost-containment measures. *See, e.g., Baxter v. Lynn*, 886 F.2d 182, 185, *reh’g denied*, \_\_\_\_ F.2d \_\_\_\_ (8th Cir. 1989) (Missouri common law limitation on subrogation); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) (Arizona anti-subrogation law); *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988) (Michigan statute making all health coverages primarily responsible and making no-fault motor vehicle coverages secondarily responsible

for benefits concerning injuries sustained in motor vehicle accidents); *Hunt v. Sherman*, 345 N.W.2d 750 (Minn. 1984) (Minnesota common law restriction on subrogation). If the decision in this case is allowed to stand, there is little doubt that states with such laws will increasingly attempt to enforce them and other states will consider adopting similar laws.

These state laws effectively mandate that employee welfare benefit plans provide specific risk insurance coverage, such as coverage for injuries incurred in motor vehicle accidents, even though such coverage is available from the specific risk insurers. Coordination laws, such as the Michigan statute at issue in *Northern Group*, authorize motor vehicle no-fault insurers and their insureds to dictate when employee benefit plans must pay benefits and what amount of benefits they must pay in contravention of the plans’ terms as set forth in their plan documents. Through such laws, state legislators, who are subject to extensive lobbying campaigns by the insurance industry, can lower specific risk insurance premiums and transfer the cost of insuring such specific risks from specific risk insurers, such as no-fault motor vehicle insurers, to employee benefit plans. Thus, the Fund’s assets will be used to subsidize the specific risk insurance coverage of participants and beneficiaries who reside in states with such laws. This results in a tremendous windfall for these specific risk insurers, which are generally profit-based companies, and an equally tremendous drain on self-funded employee benefit plans, which are non-profit entities. Moreover, assuming for purposes of argument that a plan could afford such a subsidy, which assumption is extremely unlikely, plan assets would not be uniformly used in the best interest of all participants and beneficiaries because the contributions made to the plan on behalf of

participants and beneficiaries in states without such laws would be used to subsidize the lower specific risk insurance premiums of those residing in states with such laws. Thus, the end result of these state laws is that employee benefit plans are forced to either duplicate benefits or to provide benefits in lieu of the specific risk insurer.

The proverbial floodgates of litigation, which have already been opened by the vague and differing preemption tests adopted by the Third and Sixth Circuits, will be pushed further open.<sup>9</sup> Unless this Court refuses to adopt the vague tests advanced by the Third and Sixth Circuits, multi-state employee benefit plans, which are struggling to meet increasing medical costs, will have to expend considerable plan assets on expensive litigation in states throughout the nation. Moreover, these plans cannot avoid this litigation because, *inter alia*, they cannot afford to eliminate these cost-containment measures and they cannot afford to administer a different plan in each

<sup>9</sup> As a result of the *Northern Group* decision, considerable litigation has ensued, and the cases listed below represent a small fraction of the cases filed concerning the application of the Michigan No-Fault Insurance Act to self-funded employee benefit plans: *Auto Club Ins. Ass'n v. Frederick & Herrud, Inc.*, 433 Mich. 900 (1989), petition for cert. filed, *Thorn Apple Valley, Inc. v. Auto Club Ins. Ass'n*, \_\_\_ U.S.L.W. \_\_\_ (U.S. Dec. 29, 1989) (No. 89-1125); *Central States, Southeast and Southwest Areas Health and Welfare Fund v. Hawkeye-Security Ins. Co.*, \_\_\_ U.S. \_\_\_, 109 S.Ct. 783 (1989); *Winstead v. Indiana Ins. Co.*, 855 F.2d 430 (7th Cir. 1988), cert. denied, \_\_\_ U.S. \_\_\_, 109 S.Ct. 839 (1989); *Liberty Mutual Ins. Co. v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384, reh'g denied, \_\_\_ F.2d \_\_\_ (6th Cir. 1989).

In fact, the Sixth Circuit has recently issued another decision in the *Northern Group* case which will undoubtedly cause another massive wave of litigation. In its most recent decision, the Sixth Circuit has ruled that, while it determined that ERISA did not preempt Section 500.3109a of the Michigan No-Fault Insurance Act, it did not decide the issue of whether a self-funded employee benefit plan comes within the scope of Section 500.3109a. (The slip opinion issued by the Sixth Circuit is reprinted in the Appendix, p. 1a, *infra*.)

state in which they operate. Thus, the nightmare of patchwork regulation of employee benefit plans by the states, which Congress intended to avoid by enacting Section 514 of ERISA, is becoming a reality. Accordingly, the Fund urges this Court to reverse the decision of the Third Circuit in this case and follow the precedent clearly established by this Court in requiring broad preemption of state law under Section 514 of ERISA.

## CONCLUSION

For the reasons discussed herein, this Court should reverse the decision of the United States Court of Appeals for the Third Circuit in this case and hold that Section 514 of ERISA preempts Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law.

Respectfully submitted,

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April 20, 1990

## **APPENDIX**



RECOMMENDED FOR FULL TEXT PUBLICATION

See Sixth Circuit Rule 24

No. 89-1053

UNITED STATES COURT OF APPEALS  
FOR THE SIXTH CIRCUIT

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NORTHERN GROUP SERVICES, INC.; MASCO INDUSTRIES, INC., Benefit Plan for Hourly Employees of Forming Technology; MASCO INDUSTRIES, INC., Employees' Benefit Plan for Salaried Employees; MASCO INDUSTRIES, INC., Self-Funded Employee Benefit Plans; HIGHLAND APPLIANCE COMPANIES, Medical Benefit Plan,

Plaintiffs-Appellants,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY; AUTO OWNERS INSURANCE COMPANY; AUTO CLUB INSURANCE ASSOCIATION; FARMERS INSURANCE EXCHANGE; CITIZENS INSURANCE COMPANY OF AMERICA; MICHIGAN INSURANCE COMPANY; ALLSTATE INSURANCE COMPANY, jointly and severally,

Defendants-Appellees.

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On Appeal from the United States District Court  
for the Eastern District of Michigan

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Decided and Filed March 21, 1990

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Before: MERRITT, Chief Judge; MARTIN, Circuit Judge;  
and BROWN, Senior Circuit Judge.

MERRITT, Chief Judge. In a previous appeal in this action, our Court published on November 13, 1987, an opinion, *Northern Group Servs., Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir., 1987), *cert. denied*, 108 S.Ct. 1754 (1988), holding that the three preemption provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1144(a), 1144(b)(2)(A) and 1144(b)(2)(B), when read together, do not preempt § 3109a of the Michigan Insurance Code, M.C.L.A. § 500.3109a, insofar as it establishes coordination of benefit rules between automobile insurance and "health and accident coverage." The appeal in the previous case was from a district court ruling that the federal statute preempted the state statute, occupying the field of state coordination of benefit rules. We reversed that ruling and remanded the case to the District Court for further proceedings. The District Court then held on remand that this Court's previous opinion had interpreted § 3109a to apply to self-funded or self-insured ERISA benefit plans as well as insured plans *as a matter of state law*: "The Court concludes that the Sixth Circuit has ruled that § 3109a of the Michigan Insurance Code applies to plaintiff-employee benefit plans *as a matter of state law*. . . ." J.A. at 23 (emphasis added).

This ruling by the District Court was in error. We ruled only on the federal claim of preemption, the federal issue then before us, and did not attempt to rule on any pending state claim requiring an explication of state law. We did not consider or rule, for example, on the question whether uninsured ERISA plans constitute "health and accident coverage" and thus whether § 3109a—as a matter of state law—applied to self-insured ERISA plans. For purposes of deciding the federal preemption question, and that question only, we merely assumed, without deciding,

that the coordination rules of § 3109a applied to both insured and uninsured ERISA plans. We referred to the fact that Michigan had "developed a substantial and complex body of common law and statutory principles to resolve questions of priority that arise when multiple coverage produces conflicts of the type presented in this case." *Northern Group Servs.*, 833 F.2d at 94. We did not attempt to precisely define those state law rules as they apply to various forms of coverage or ERISA plan benefits.

It was unnecessary for us to interpret § 3109a in any detail because in our previous case we only had to decide whether the preemption provisions of ERISA, *e.g.*, § 1144(a) (ERISA "shall supersede . . . State laws insofar as they . . . relate to any employee benefit plan") (emphasis added) and § 1144(b)(2)(B) (a provision saving from preemption "any law . . . purporting to regulate insurance"), should be interpreted to occupy the field of state coordination of insurance benefit rules, not whether a specific, isolated state coordination rule conflicts with a specific provision in an ERISA plan. For background concerning the various federal preemption principles, including "occupation of the field" preemption, see generally *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747-48 (1985); *Jones v. Truck Drivers Local Union No. 299*, 838 F.2d 856, 868-75 (6th Cir. 1988); Field, *Sources of Law: The Scope of Federal Common Law*, 99 Harv.L.Rev. 88-1 (1986).

Our previous opinion states in the first sentence that the question presented was whether ERISA preempts Michigan law "*to the extent that the Michigan law allows policy provisions [on coordination of insurance benefits] which conflict with ERISA plans.*" *Northern Group Servs.*, 833 F.2d at 86 (emphasis added). We then explored the legislative history of the ERISA preemption provisions.

We did not explore the legislative history of the Michigan law or make any attempt to analyze which types of insurance or employee benefits fall under § 3109a.

The District Court judgment holding that our previous decision made a conclusive interpretation of § 3109a of the Michigan Code as a matter of state law is, therefore, in error. Its ruling that we concluded that § 3109a applied to self-insured ERISA plans is reversed. The case is remanded to the District Court.

The District Court on remand should treat the state law issues concerning the application of § 3109a of the Michigan Insurance Code as pendent state claims. It should exercise its discretion to retain and decide those pendent state issues under the principles established in *United Mine Workers v. Gibbs*, 383 U.S. 715, 726-27 (1966); *Gaff v. Federal Deposit Ins. Corp.*, 814 F.2d 311, 319 (6th Cir. 1987); *Beuth v. Brit Airlines, Inc.*, 749 F.2d 1235, 1240-41 (7th Cir. 1984), and other similar cases creating and applying standards to guide district courts in exercising jurisdiction over pendent state claims after the federal issue in the case has been decided.

Accordingly, the judgment of the District Court is reversed and the case remanded for disposition in accordance with this Court's instructions.

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No. 89-1048

Supreme Court, U.S.

FILED

APR 20 1990

JOSEPH F. SPANIO, JR.  
CLERK

IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1989

FMC CORPORATION,

v.

*Petitioner,*

CYNTHIA ANN HOLLIDAY,

*Respondent.*

On Writ of Certiorari to the United States  
Court of Appeals for the Third Circuit

BRIEF OF THE CHAMBER OF COMMERCE OF THE  
UNITED STATES OF AMERICA, AS AMICUS CURIAE,  
IN SUPPORT OF THE PETITIONER

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IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1989

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No. 89-1048

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FMC CORPORATION,  
v. *Petitioner,*

CYNTHIA ANN HOLLIDAY,  
*Respondent.*

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On Writ of Certiorari to the United States  
Court of Appeals for the Third Circuit

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BRIEF OF THE CHAMBER OF COMMERCE OF THE  
UNITED STATES OF AMERICA, AS AMICUS CURIAE,  
IN SUPPORT OF THE PETITIONER

---

**INTEREST OF AMICUS CURIAE**

With the written consent of the parties,<sup>1</sup> the Chamber of Commerce of the United States ("Chamber") submits this brief as amicus curiae in support of the Petitioner. The Chamber is the nation's largest federation of business, trade and professional organizations in the United States. It represents the interests of over 180,000 corporations, partnerships and proprietorships, as well as several thousand state and local chambers of commerce and trade associations. An important function of the Chamber is to represent the interests of its member employers in important labor relations matters before this

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<sup>1</sup> Pursuant to Supreme Court Rule 37.2, the consent letters have been filed with the Clerk of this Court.

Court, the lower courts, the United States Congress, the Executive Branch and independent regulatory agencies of the federal government. This representation constitutes a significant aspect of the Chamber's activities. Accordingly, the Chamber has sought to advance those interests by filing briefs in a wide spectrum of labor relations litigation,<sup>2</sup> including this case, in which the Chamber urged the Court to grant certiorari.

In the decision below, the Third Circuit Court of Appeals rejected this Court's bright-line preemption test under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, which established that state regulation of uninsured employee benefit plans is preempted by ERISA, even where the state acts through its insurance laws which are generally "saved" from preemption. Instead, the Court of Appeals crafted its own test, permitting a Pennsylvania anti-subrogation law to apply to uninsured plans, because the law purportedly did not address "core ERISA concerns."

The Third Circuit decision threatens to disrupt the ability of many Chamber members to continue to maintain and operate their self-insured employee benefit plans. It also jeopardizes the financial stability of uninsured, collectively bargained multiemployer plans, to which many Chamber members contribute. By prohibiting uninsured plans from using subrogation rules as a cost containment mechanism, the Third Circuit decision will inevitably result in substantial increases in the benefit costs of these plans. Further, the decision will encourage other states to delve into employee benefit plan regulation, which will increase administrative costs and expose uninsured plans to the threat of conflicting re-

<sup>2</sup> *E.g.*, *Trans World Airlines, Inc. v. Independent Federation of Flight Attendants*, 109 S.Ct. 1225 (1989); *Laborers Health and Welfare Trust Fund v. Advanced Lightweight Concrete Co., Inc.*, 484 U.S. 539 (1988); *Pattern Makers League v. NLRB*, 473 U.S. 95 (1985).

quirements. Chamber members thus have a compelling interest in seeking to prevent any erosion in this Court's commitment to comprehensive federal preemption. This interest puts the Chamber in a position to provide the Court with a more complete understanding of the potential impact of the Third Circuit decision, and of the necessity for this Court to act to preserve both the viability of uninsured benefit plans and their exclusively federal scheme of regulation.

### SUMMARY OF ARGUMENT

In attempting to "make sense" of ERISA's interlocking preemption provisions, the United States Court of Appeals for the Third Circuit has adopted an unprecedented approach which purports to permit a "rational system" of state and federal law to apply uniformly to insured and uninsured employee benefit plans. Rejecting the unanimous view of eight Justices of this Court, who held that ERISA preempts the application of state insurance laws to uninsured plans, the Third Circuit concluded that state laws purporting to regulate "insurance" may apply to uninsured employee benefit plans as long as they do not address "core ERISA concerns." In adopting this approach, however, the Court of Appeals ignored fundamental, historical distinctions between the business of insurance and employee benefit plans, and overlooked critical differences between insured and uninsured plans—differences which render uninsured plans acutely vulnerable to the threat of dual state and federal regulation.

Several factors support the application of different rules under ERISA for insured and uninsured plans. First, Congress' decision to save state insurance laws from ERISA preemption was consistent with its deferral to state regulation in the McCarran-Ferguson Act of 1945, Ch. 20, 59 Stat. 33 (1945), and its decision at that time that continued state regulation of the business

of insurance was in the public interest. By contrast, when Congress enacted ERISA in 1974, it determined that adequate safeguards concerning the operation of employee benefit plans were lacking, thus making federal regulation of those plans desirable.

Second, the nature and operation of employee benefit plans make it inappropriate for them to be subject to state insurance laws designed to regulate commercial businesses and to protect consumers. While insurance companies are businesses, selling consumer products to the public, welfare benefit plans are non-profit entities which exist to provide benefits only to sponsoring employers' employees. They do not market their products to outside groups or to the public at large.

Third, Congress could not have accomplished its goal of eliminating the threat of conflicting and inconsistent employee benefit plan regulation without exempting uninsured plans from state regulation. Although a plan which purchases an insurance policy may rely on the insurance company to comply with any state laws affecting the company, an uninsured plan subject to state insurance laws would itself become responsible for sorting through various and conflicting state requirements. By failing to recognize the adverse impact that its decision would have on uninsured plans, and by ignoring the intent of Congress to eliminate a "patchwork scheme of regulation," the Third Circuit reached a conclusion which can never make sense under the ERISA regulatory scheme.

If, as a result of the decision below, uninsured plans are now forced to comply with various state insurance laws, their administrative costs will undoubtedly increase. More significantly, the Third Circuit analysis will drive up the benefit costs of uninsured plans. Subrogation rules are included in many plans' cost containment efforts, and are designed to maximize the protection available to all plan participants by providing bene-

fits only to those individuals who have no other avenues of recovery. If employers and plan administrators are prevented from using these cost containment features, benefit costs will increase.

In order to respond to the pressures created by state-mandated benefit increases, employers may conclude that they have to reduce plan benefits. One alternative, already embraced by some plans, would be to eliminate coverage entirely for medical costs arising out of automobile accidents. If injuries and illnesses arising out of automobile accidents are not covered at all by a plan, the subrogation issue would not arise. A change in coverage of this magnitude, however, could have disastrous consequences for the participants of uninsured plans. In some cases, participants may have no coverage at all for their medical claims. Thus, instead of permitting double recoveries, as the Pennsylvania statute was designed to do, state anti-subrogation laws may result in no available recovery for individuals otherwise covered by employee benefit plans.

Finally, the vagueness of the "core ERISA concerns" test virtually guarantees a long period of uncertainty during which the states will test the outer limits of their newly-found authority to regulate plans. Plans and employers, on the other hand, will be fighting to preserve some semblance of ERISA's originally intended preemption, while at the same time struggling to comply with conflicting laws. When these conflicting interests are brought before the federal courts, judges will be forced to sort through an endless series of disputes over the meaning and scope of the Third Circuit test. Accordingly, this Court should reverse the decision below and restore order to the regulation of employee welfare benefit plans.



## ARGUMENT

### I. THE THIRD CIRCUIT'S ATTEMPT TO "MAKE SENSE" OUT OF ERISA'S PREEMPTION PROVISIONS FAILS BECAUSE IT IGNORES FUNDAMENTAL DISTINCTIONS BETWEEN THE BUSINESS OF INSURANCE AND EMPLOYEE BENEFIT PLANS, AND BETWEEN INSURED AND UNINSURED PLANS

The Third Circuit's unprecedented preemption analysis is rooted in its desire to "make sense" of ERISA's interlocking preemption provisions.<sup>3</sup> *FMC Corp. v. Holliday*, 885 F.2d 79, 88 (3d Cir. 1989) ("FMC"). However, in its attempt to create a "rational system" of state and federal law which would apply uniformly to insured and uninsured employee benefit plans,<sup>4</sup> the Third Circuit

<sup>3</sup> Section 514(a) of ERISA generally provides that the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." Section 514(b)(2)(A), often referred to as the "savings" clause, states that except as provided in subparagraph (B), nothing in Title I of ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(a), (b)(2)(A). Section 514(b)(2)(B) of ERISA, known as the "deemer" clause, provides that "[n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts. . . ." 29 U.S.C. § 1144(b)(2)(B).

<sup>4</sup> The Third Circuit relied heavily in its decision on the analysis of the Sixth Circuit Court of Appeals in *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), cert. denied, 108 S.Ct. 1754 (1988) ("*Northern Group Services*"), which held that ERISA does not preempt the application of state-mandated coordination of benefits rules under a Michigan no-fault automobile insurance law to uninsured plans. Both of these Circuit Courts strained to reach a result preserving a uniform application of state laws to all employee benefit plans, "so that benefit obligations are governed by a rational system of state law and federal

ignored fundamental, historical distinctions between the business of insurance—which may be regulated by the states—and employee benefit plans, which may not. The Third Circuit approach also ignored critical differences between insured and uninsured plans—differences which render uninsured plans acutely vulnerable to the threat of dual state and federal regulation.

In reaching its desired result, the Third Circuit ignored this Court's carefully reasoned ERISA preemption analysis in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985) ("*Metropolitan Life*"). In *Metropolitan Life*, the Court held that where an employee benefit plan purchases an insurance contract from an insurance carrier subject to state regulation, the plan may be subject to indirect state regulation because ERISA expressly excludes from its broad preemption provision state laws regulating insurance. 471 U.S. at 747; Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A). Where an employee benefit plan is uninsured, however, it may not be subject to state insurance laws, because ERISA expressly prohibits the states from deeming an employee benefit plan to be an insurance company or in the business of insurance for purposes of a state law regulating insurance. *Metropolitan Life*, 471 U.S. at 747; Section 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B).

#### A. Historical And Functional Differences Between The Business Of Insurance And Employee Benefit Plans Justify Different Rules Under ERISA

Significant distinctions between the business of insurance and the operations of employee benefit plans support the Congressionally-designed regulatory scheme prohibiting the application of state laws where true insurance is not involved. When Congress chose to "save"

common law." *FMC*, 885 F.2d at 84, quoting *Northern Group Services*, 833 F.2d at 89.

from preemption state laws regulating insurance, it was doing no more than continuing its historical deferral to state regulation in this area. The insurance industry has traditionally been subject to extensive state regulation—indeed, Pennsylvania insurance legislation dates back to at least 1810. Pa. Stat. Ann. tit. 40 §§ 1 to 720, Introduction p. XXI (Purdon 1971).

Congress' decision to save state insurance laws from ERISA preemption was consistent with its declaration in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.* (1976 & Supp. V 1982), "that the continued regulation and taxation by the several states of the business of insurance is in the public interest." By contrast, Congress determined when it enacted ERISA that despite the recent growth in size, scope, and numbers of employee benefit plans, adequate safeguards concerning their operation were lacking, thus making federal regulation desirable. See Findings and Declaration of Policy, Section 2(a) of ERISA, 29 U.S.C. § 1001(a).

Allowing the states to continue to regulate insurance companies, while preventing them from regulating employee benefit plans, had a logical as well as historical basis. Insurance companies (which generally operate on a for-profit basis) are businesses, selling traditionally-regulated consumer products to unrelated customers. Insurance companies compete with each other for business, and advertise and market their products within the business community and to the public at large.

By contrast, uninsured employee welfare benefit plans are not in the business of selling consumer insurance products. They are non-profit entities that exist to provide benefits only to sponsoring employers' employees. They do not market their wares to outside groups or to the public, and they do not attempt to broaden their base by selling coverage to unrelated beneficiaries. These distinctions more than justify Congress' refusal to permit the states to extend application of their traditional,

consumer-protection insurance statutes directly to employee benefit plans.<sup>5</sup>

#### **B. Uninsured Plans Have A Particular Need For Complete Protection From State Insurance Laws**

Even more importantly, however, critical distinctions between the operations of insured and uninsured plans meant that the Congressional goal of "eliminating the threat of conflicting and inconsistent State and local regulation"<sup>6</sup> of employee benefit plans could not have been accomplished without a comprehensive clause protecting uninsured plans from state regulation. State regulation of the business of insurance and of insurance companies did not threaten the viability of employee benefit plans, even where those plans purchased insurance policies. In contrast, Congress had to exempt uninsured plans from state regulation in order to ensure that those plans would not be overwhelmed by conflicting requirements.

When an employer or employee benefit plan purchases insurance from an insurance company, the plan does not itself become subject to state laws or responsible for determining the insurance company's compliance in various states. It is the insurance company's obligation to monitor the state laws that are applicable to it, and to make certain that the insurance contracts it sells are in compliance with those laws. Assumption of the ad-

<sup>5</sup> State insurance laws are commonly understood to be consumer protection statutes, regulating the sale of consumer products. See Collins, *Regulation Best on State Level: Washburn*, Bus. Ins., May 2, 1988, at 69; Howard, *States to Keep Ins. Regulation*, Nat'l Underwriter, June 26, 1989, at 3; Fisher, *Agents, Consumer Groups Seek Regulatory Standards*, Nat'l Underwriter, June 12, 1989, at 1; Jones, *The Industry Doesn't Need a Federal 'Czar'*, Nat'l Underwriter, November 7, 1988, at 19.

<sup>6</sup> 120 Cong. Rec. 29197 (1974) (statement of Rep. John Dent), quoted in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983).



ministrative burden associated with different state insurance laws is an essential component of the insurance product purchased by an employee benefit plan.

Thus, the states do not in fact regulate the employee benefit plans that purchase insurance policies. Rather, the insurance companies are regulated, and plans simply choose among the types of policies that the various states permit to be marketed.

By contrast, if the decision below is not overturned, and if state insurance laws are applied to uninsured employee benefit plans, the plans themselves will be required to monitor and comply with extensive state regulation. This Court has already found that Congress intended ERISA's preemption provision to eliminate "[a] patchwork scheme of regulation," because the inefficiencies introduced thereby "might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 11 (1987). As the Court recognized, "[p]reemption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Id.*

By ignoring critical distinctions between insured and uninsured plans, the Third Circuit failed to recognize that it could never make sense under the ERISA scheme of regulation to permit states to apply their insurance laws directly to employee benefit plans. If the Third Circuit decision is not reversed, those plans and their sponsoring employers will be forced to shoulder the burden of dual and conflicting regulation. Thus, despite the Third Circuit's rejection of the logic behind this Court's decision in *Metropolitan Life*, the preemption analysis so clearly articulated in that case must remain intact.

## II. IF THE THIRD CIRCUIT DECISION IS NOT REVERSED, UNINSURED PLANS WILL BE FORCED TO RESPOND TO UNWARRANTED INCREASED ADMINISTRATIVE AND BENEFIT COSTS, WHICH MAY JEOPARDIZE THE CONTINUED DELIVERY OF COMPREHENSIVE MEDICAL BENEFITS TO PLAN PARTICIPANTS

An employer's choice to self-insure its employee health plan is most often an economic decision—administrative costs for uninsured plans are generally lower than for insured plans.<sup>7</sup> In addition, employers insuring their own plans can achieve savings by holding onto cash until claims are paid, instead of paying premiums in advance to an insurer.<sup>8</sup> These cost-saving devices are extremely important to health plans, because employers are limited in the amounts they can make available to finance plan benefits. Where plans are funded, such as in the case of collectively-bargained, jointly administered plans, the trusts derive their assets solely from limited negotiated contributions and the interest generated by any reserves held. In addition, contribution levels are often fixed for the terms of the underlying collective bargaining agreements and may lag behind ever-rising medical plan costs.

Despite the administrative cost savings that are generally available to uninsured plans, there has been a

<sup>7</sup> Burke, *Administrative Costs Lower Among Self Insurers: Study*, Bus. Ins., February 13, 1989 at 28, citing Foster Higgins, *Health Care Benefits Survey—1988*, at 24 (health care administrative expenses for self-insured employers total 5.2% of claims, while insured employers' administrative expenses total 6.6% of paid claims). One author attributes recent growth in self-insurance to ever-increasing health premium costs. See Donahue, *53% of Group Health Plans Are Now Self-Insured: HIAA*, Nat'l Underwriter, June 13, 1988, at 13 (based on a 1987 survey of 771 employers by the Health Insurance Association of America).

<sup>8</sup> Foster Higgins, *supra* note 7, at 23.



dramatic upturn in medical plan costs in recent years.<sup>9</sup> Although this increase has affected both insured plans and uninsured plans, uninsured plans experienced its impact sooner.<sup>10</sup> If, as a result of the Third Circuit decision, uninsured plans are now forced to comply with various state insurance laws, their administrative costs will undoubtedly increase.

Even more significant, however, is that the Third Circuit analysis will drive up the benefit costs of uninsured plans. As a result of increased medical costs, plan administrators and plan boards of trustees have been forced to rely on aggressive cost containment measures. Subrogation rules and plan-created coordination of benefits provisions, like those struck down by the Third Circuit in the decision below and by the Sixth Circuit in *Northern Group Services*, 833 F.2d 85, are designed to maximize the protection available to all participants by denying coverage or limiting benefits in many cases where individuals have other avenues of recovery.<sup>11</sup> If

<sup>9</sup> Shalowitz, *Self-Insurance—Self-Funding Benefits at Peak of Popularity?*, Bus. Ins., January 30, 1989, at 3.

<sup>10</sup> Foster Higgins, *supra* note 7, at 22. The Foster Higgins Survey made the following comment with respect to 1988 cost increases:

The severity of this year's increase took many by surprise—including, it seems, the insurance industry. Employers with insured programs experienced an average increase of only 13.7 percent in 1988. Self-funded plans, on the other hand, averaged a 24.8 percent increase in the same period. Clearly, the projected trend for 1988, as reflected in the rate of increase for insured plans, was far exceeded by the actual experience during the period, as demonstrated by the experience of the self-funded employers. It is likely that those fully insured or experience-rated plans will find their 1989 premiums reflecting the deficit caused by the understated 1988 trend.

*Id.* at 12.

<sup>11</sup> The savings derived from rules of this type can be substantial: Savings arising from enforcement of Coordination of Benefits (COB) provisions averaged 5.1 percent of total plan payments in 1988, ranging from an average of 4.9 percent among em-

employers and plan administrators are now to be prevented from using these cost containment features of plan design, benefit costs will increase.

In order to respond to the pressures created by state-mandated benefit increases, employers may conclude that they have to reduce plan benefits. Employers could choose to reduce benefits across-the-board, or to address the benefit increases caused by state anti-subrogation laws more directly. One alternative for plans subject to the statute addressed in *FMC* would be to eliminate coverage entirely for medical costs arising out of automobile accidents. If injuries and illnesses arising out of automobile accidents are not covered at all by the plan, the subrogation issue would not arise. *Cf. Liberty Mutual Insurance Group v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384 (6th Cir. 1989) (coordination of benefits rules of Michigan no-fault insurance laws preempted where health plan excluded coverage for automobile accidents).

As demonstrated by the *Liberty Mutual* decision, plans have already begun to embrace this alternative as a means of avoiding the benefit increases that would result from the Third and Sixth Circuit decisions. A change in coverage of this magnitude, however, could have disastrous consequences for the participants of uninsured plans. In some cases, participants may have no coverage at all for their medical claims.<sup>12</sup> Thus, instead

employers using commercial carriers to an average of 5.8 percent among self-administered employers.

Foster Higgins, *id.* at 27.

<sup>12</sup> For example, in the instant case, Respondent Holliday was limited in her recovery from the alleged tortfeasor in her automobile accident case to approximately \$50,000, despite the fact that her medical bills have thus far exceeded twice that amount. An uninsured motorist or pedestrian who finds himself at fault in an automobile accident might have no avenue of recovery if coverage is denied under his employee benefit plan.

of permitting double recoveries, as the Pennsylvania statute was designed to do, state anti-subrogation laws may result in no available recovery for individuals otherwise covered by employee benefit plans.

Moreover, many employers and plans have routinely covered the medical benefit costs of employees in situations where plan coverage was in question, as a convenience to these employees. In cases where an employee's recovery from another entity is uncertain or likely to be delayed for some period of time, as in Respondent Holliday's case, a plan's early provision of benefits performs a genuine service. Subrogation rules have served to protect the employers and plans from ultimately being responsible for benefits that were not intended to be covered. If statutes such as Pennsylvania's anti-subrogation law are held to survive ERISA preemption, this early and necessary protection for employees injured in automobile accidents may be eliminated. These victims could then be subjected to serious delays in securing reimbursement for medical costs. Further, any open question as to an individual's eventual recovery of medical costs could affect his ability to receive the medical care of his choice.

### III. IF LEFT UNDISTURBED, THE THIRD CIRCUIT DECISION WILL PROVOKE UNCERTAINTY AND FOSTER UNNECESSARY LITIGATION AS THE FEDERAL COURTS STRUGGLE TO APPLY AN INHERENTLY CONFUSING AND UNWORKABLE PREEMPTION TEST

The vagueness of the "core ERISA concerns" test—under which state laws purporting to regulate "insurance" may be applied to uninsured employee benefit plans as long as they address areas other than reporting, disclosure and nonforfeatability of benefits<sup>13</sup>—virtually

<sup>13</sup> Although the opinion is far from clear, the Third Circuit's discussion of the legislative history of ERISA's preemption provision suggests that the area of fiduciary responsibility would also be a "core ERISA concern." See *FMC*, 885 F.2d at 87-88. In

guarantees a long period of uncertainty during which the states will test the outer limits of their newly-found authority to regulate plans. Plans and employers, on the other hand, will be fighting to preserve some semblance of ERISA's originally intended preemption, while at the same time struggling to comply with conflicting laws.

Any state that accepts the Third Circuit's open invitation to regulate employee welfare plans can be expected to attempt to apply the same extensive requirements that are prevalent in state insurance regulation to employee benefit plans. Although it would be impossible to predict just how far the states will be willing to go in this area, one can assume that various (and conflicting) anti-subrogation rules and coordination of benefits laws will be imposed, along with rules relating to benefits processing and the timeliness of payment of claims.<sup>14</sup> The states may even attempt to impose minimum asset (actuarial reserve) requirements and other traditional "insurance" obligations on uninsured plans.<sup>15</sup> The possibilities are endless, and all are contrary to this Court's preemption analysis and the Congressional intent underlying ERISA.

— addition, the Third Circuit's designation of nonforfeatability as a "core ERISA concern" suggests that other subject areas covered by ERISA might also be considered "core" matters, even though they (like nonforfeatability) are not applicable to welfare plans. See Section 201(1) of ERISA, 29 U.S.C. § 1051(1) (excluding employee welfare benefit plans from ERISA's nonforfeatability rules).

<sup>14</sup> See, e.g., Ill. Ann. Stats., Chap. 73, §§ 964, 969 (Smith-Hurd 1988); Ohio Rev. Code Ann. § 3901.38 (Anderson 1989); Tenn. Code Ann. § 68-11-219 (1988). These rules would directly conflict with ERISA's claims procedure requirements, see 29 C.F.R. § 2560.503-1 (1989), but could, nonetheless, be found not to address reporting, disclosure and nonforfeatability.

<sup>15</sup> See, e.g., Pa. Stat. Ann. tit. 40, § 93 (Purdon 1971). Actuarial reserve requirements are nothing more than minimum funding requirements, which ERISA limits to pension plans. See Section 301(a)(1), 29 U.S.C. § 1081(a)(1). Again, however, a state could assert under the authority of *FMC* that these requirements do not relate to reporting, disclosure or nonforfeatability.



Yet, in the face of the decision below, the prospects for employers having to face these possibilities are quite real.

Employers, plans and plan participants will not be alone in shouldering burdens created by the Third Circuit's faulty preemption analysis. The federal courts will face enormous difficulties in attempting to apply the "core ERISA concerns" test—difficulties that are inherent in the Third Circuit's own application of its creation.

For example, that court failed to recognize that a state anti-subrogation law affects the forfeitability of benefits under a welfare plan. The FMC plan covers medical costs arising out of automobile accidents, but benefits paid are subject to recapture by the plan in the event of another recovery. The Pennsylvania subrogation law, however, prohibits any right of subrogation or reimbursement from a participant's tort recovery with respect to medical claims paid. *See* 75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1984). By prohibiting the FMC plan from enforcing the conditional nature of the benefits, the Pennsylvania law treats the benefits as "vested." Thus, the law in fact addresses the "core ERISA concern" of nonforfeitability.<sup>16</sup>

This is obviously troublesome because Congress explicitly chose not to extend ERISA's vesting requirements to health and welfare plans. *See In Re: White Farm Equipment Co.*, 788 F.2d 1186 (6th Cir. 1986) (no absolute rule requiring mandatory vesting of retiree medical benefits; Congress expressly exempted welfare plans from stringent vesting, participation and funding re-

<sup>16</sup> *Cf. Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (New Jersey law prohibiting offset of pensioner's workers' compensation benefits against his pension is preempted by ERISA; offset would ordinarily constitute impermissible forfeiture under ERISA, but is specifically permitted under lawful regulations of Internal Revenue Code).

quirements); *see also Metropolitan Life*, 471 U.S. at 732 (ERISA does not regulate substantive content of welfare benefit plans), *citing Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 91.

Most disturbing of all, however, is that the Third Circuit was unable to apply its own test in a rational manner, which can only portend great confusion and uncertainty for other courts if the "core ERISA concern" rule is upheld. This Court might even have to reconsider the unanimous conclusion of the eight Justices who determined in *Metropolitan Life* that a state insurance law mandating particular benefits was preempted in its application to uninsured employee benefit plans. State mandated benefit laws generally fall outside of the areas the Third Circuit identified as subject to preemption (i.e., reporting, disclosure, and nonforfeitability), and indeed, regulate an area which Congress expressly declined to touch.<sup>17</sup> The fact that the Third Circuit's unique preemption analysis would call into question a unanimous decision of this Court demonstrates its utter fallibility and its completely unworkable nature.

If the decision below is not reversed, the viability of the nation's uninsured welfare benefit plans will be threatened, the benefit security of millions of plan participants will be jeopardized, and the federal courts will be forced to sort through an endless series of disputes over the meaning and scope of the Third Circuit test. This Court should reverse the decision below and restore order to the regulation of employee welfare benefit plans.

<sup>17</sup> ERISA leaves the question of which benefits will be provided under a plan to the private parties creating it. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).



**CONCLUSION**

The decision of the United States Court of Appeals for the Third Circuit should be reversed.

Respectfully submitted,

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IN THE  
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OCTOBER TERM, 1989

FMC CORPORATION,

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*Respondent.*

On Writ of Certiorari to the  
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**AMICI CURIAE BRIEF OF  
THE TEAMSTERS HEALTH AND WELFARE FUND  
OF PHILADELPHIA & VICINITY,  
THE WESTERN PENNSYLVANIA TEAMSTERS AND  
MOTOR CARRIERS WELFARE FUND,  
THE DAIRY INDUSTRY-UNION HEALTH AND  
WELFARE FUND OF PHILADELPHIA & VICINITY,  
IBEW LOCAL UNION NO. 98 HEALTH AND  
WELFARE FUND, AND CENTRAL PENNSYLVANIA  
TEAMSTERS HEALTH AND WELFARE FUND  
IN SUPPORT OF THE PETITIONER**

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**AMICI CURIAE BRIEF OF  
THE TEAMSTERS HEALTH AND WELFARE FUND  
OF PHILADELPHIA & VICINITY,  
THE WESTERN PENNSYLVANIA TEAMSTERS AND  
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THE DAIRY INDUSTRY-UNION HEALTH AND  
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WELFARE FUND, AND CENTRAL PENNSYLVANIA  
TEAMSTERS HEALTH AND WELFARE FUND  
IN SUPPORT OF THE PETITIONER**

**INTEREST OF THE AMICI CURIAE**

This brief, which urges reversal of *FMC Corp. v. Holliday*, 885 F.2d 79 (3d Cir. 1989), *cert. granted*, 58 U.S.L.W. 3526 (U.S. Feb. 20, 1990), is submitted on behalf of five multi-employer welfare plans (collectively designated the "Funds") established pursuant to § 302 (c) (5) of the Labor Management Relations Act, 29 U.S.C. § 186(c) (5) ("LMRA"), and § 3(1) and (37) of the Employee Retirement Income Security Act, 29 U.S.C. §§ 1002 (1) and (37) ("ERISA"). Each Fund is based in Pennsylvania and, thus, presently covered by the Third Circuit's decision. The Funds exist for the exclusive purpose of providing health care benefits to participating employees and their dependents and are administered by Trustees, appointed in equal numbers by management and labor. These Trustees owe their exclusive fiduciary obligations to the participants and beneficiaries of their respective Funds. Therefore, the Trustees may not act in the interests of the employers or unions which appointed them. *NLRB v. Amax Coal Co.*, 453 U.S. 322, 332-34 (1981).

The Funds' interest in this case arises from the fact that they, like all health care providers, are presently confronted with a national crisis arising from explosive inflation in the cost of health care. Failure to combat this problem will prevent the Funds from providing adequate benefits to the men, women, and children who

rely upon them. The crisis is especially acute due to the manner in which the Funds are financed.

The Funds' income is set by collective bargaining agreements negotiated by constituent unions and employers. These agreements generally remain intact for several years. Even when labor contracts expire, there is no guarantee that labor and management can or will provide the Funds with adequate income.<sup>1</sup> Consequently, unlike insurance companies, the Funds have no power to respond to inflation by raising premiums. The only reliable alternatives for dealing with the current crisis are to cut costs or to reduce the available benefits.

To avoid reducing benefits, the Funds have implemented a series of cost containment measures, including subrogation provisions essentially identical to the policy of the FMC Salaried Health Care Plan ("FMC Plan"). Subrogation preserves finite trust assets by preventing duplicative compensation for one injury. Pennsylvania's limits on subrogation effectively require greater expenditures than necessary to provide treatment, a practice which is commonly called "double dipping." If the Third Circuit's decision remains intact, the Funds will have to expend large sums for such "double dipping." The result will be less benefits available for those eligible individuals who have no alternative source for financing medical treatment.

<sup>1</sup> See *United Mine Workers of America Health & Retirement Funds v. Robinson*, 455 U.S. 562, 570-76 (1982) (labor negotiators have an unfettered right to set contribution levels as long as they do not violate a specific federal law).

Many multiemployer plans are in industries which are either financially depressed or increasingly non-union. Since employers which contribute to such plans are often financially stressed, they have difficulty in making adequate benefit contributions. Katz, *Meltdown Forces New Look At Benefit Plan Structure*, Life & Health/Financial Services Edition, January 4, 1988 at 14. The current industrial strife caused by health care inflation further demonstrates the uncertainty inherent in relying upon the collective bargaining process. See *infra* notes 21-22, and accompanying text.

Perhaps more ominously, the logic of the Third Circuit's opinion would subject self-insured benefit plans,<sup>2</sup> including the Funds, to unlimited state interference with cost containment practices. As a legal matter, that result would flout the policies underlying ERISA. As a practical matter, such an outcome would severely injure self-insured plans and the persons who rely upon them.

# **I. THE FUNDS MUST IMPLEMENT EFFECTIVE COST-CONTAINMENT MEASURES IN ORDER TO PROVIDE ADEQUATE HEALTH CARE TO THEIR PARTICIPANTS AND BENEFICIARIES.**

## **A. The Escalating Cost of Health Care Has Caused a National Crisis.**

In 1987, the House of Representatives' Committee on Education and Labor and the Senate's Special Committee on Aging commissioned a study of health care in the United States. The final report noted that the cost of providing medical benefits "increased rapidly" from 1977 through 1983 and "slowed between 1984 and 1987." The report also cautioned that "increases for 1988 and 1989 are expected to resume the high growth rate of the early 1980's." Congressional Research Service, Library of Congress, *Health Insurance and the Uninsured: Background Data and Analysis*, pp. 65-66 (1988). Unfortunately, that prediction was prophetic.

The United States Chamber of Commerce reported that the cost of providing health care insurance to employees rose by 19% in 1988.<sup>3</sup> In 1989, costs increased an additional 20.4% nationwide, and an astounding 29.2% in

<sup>2</sup> As used herein, the terms "self-funded" and "self-insured" are synonymous, meaning a plan which pays benefits from its own corpus rather than by purchasing an insurance policy. Fifty-two percent of all employee health benefit plans, and 84 percent of those which encompass 20,000 or more workers, are self-insured. Woolsey, *Most Health Plans Now Self-funded*, Business Insurance, January 29, 1991 at 3.

<sup>3</sup> Geisel, *Health Benefit Tab Rises 19% to New High*, Business Insurance, December 11, 1989 at 1.



the mid-Atlantic states, which encompass the Funds.<sup>4</sup> The average employer's health benefit costs have risen from 5% of payroll to 18% over the last decade.<sup>5</sup> Multi-employer plans, such as the Funds, have been saddled with even higher inflation rates.<sup>6</sup> Furthermore, the AFL-CIO estimates that in the future "health care costs will continue to rise anywhere from 18 to 31 percent per year."<sup>7</sup>

<sup>4</sup> These figures are based upon a survey of 1,943 employers conducted by A. Foster Higgins & Co. See Landes, '89 *Health Costs Rose 20%*; *Employers*, National Underwriter Property & Casualty/Risk & Benefits Management Edition, February 19, 1990 at 27. See also Gaul, *Employers' Costs of Health Benefits Rose 20.4% in '89*, Philadelphia Inquirer, January 30, 1990 at C-1, col. 5; Kenkel, *Employer Costs of Group Health Benefits Take 17% Jump - Survey*, Modern Healthcare, February 5, 1990 at 3; Geisel, *Repeal of Section 89 Most Important Event for Benefit Managers*, Business Insurance, December 25, 1989 at 3, 13 ("In 1989, health care costs for indemnity plans increased 20% to 50%, while health maintenance organizations boosted premiums about 17% on average, several surveys found"); *Self-Insured Employers See Health Costs Rise 18% - Study*, Modern Healthcare, February 12, 1990 at 62; Gaul, *Area Hospitals Undergo A Shakeout*, Philadelphia Inquirer, January 16, 1990 at 1-A, 9-A, col. 3 ("Nationally health care expenditures rose from \$248 billion in 1980 to a projected \$647 billion in 1990—a 160 percent increase in a decade"); Peirce, *Health-cost Monster Needs to Be Tamed*, Philadelphia Inquirer, April 9, 1990 at 11-A, col. 5 ("[H]ealth-care costs [are] rising at three-times the rate of inflation").

<sup>5</sup> *Consensus Building, Not Legislation to Mark 1990*, Johnson Tells Conference, 17 B.P.R. (BNA) 222, 223 (January 29, 1990). See also *Employers' Labor Costs Up 5 Percent Over 1988; Most Gains on Benefit Side*, 18 Daily Lab. Rep. (BNA) B-2 (January 26, 1990) (Bureau of Labor Statistics data shows that "health insurance costs rose at double digit rates throughout the 1980's, except for 1985 to 1987").

<sup>6</sup> See Grossi, Yu, Astor & McCarthy, *The Pre-Estimate Program: An Effective Way to Reduce Surgical Fees While Preserving High Quantity Care and Patient Choice*, Employee Benefits Journal, December 1989 at 2 (noting that costs for multi-employer plans are rising "an average of 20-40%" on a national basis).

<sup>7</sup> DeWolf, *Health Care Benefits A Continuing Issue*, Philadelphia Daily News, January 12, 1990 at 81, 82, col. 1. See also 2

### 1. The Causes of the Crisis.

There is no professional consensus concerning the genesis of the problem. Expert opinion, however, focuses upon factors beyond the control of plan fiduciaries. The single largest impetus to health care inflation arises from dramatic improvements in medical technology, which are expensive and usually prolong treatment. Technological advances account for approximately 50% of the current inflation in health care.<sup>8</sup> These increases have prompted the Health Care Financing Administration to propose rules which include cost effectiveness as a criterion for Medicare funding of new technology.<sup>9</sup>

The AIDS pandemic has also fueled the crisis. According to a study by the Alexander & Alexander Consulting Group, in early 1988, "[t]he average per-case cost for treatment of AIDS was \$103,350."<sup>10</sup> That study occurred as the present health care spiral was just begin-

Milliman & Robertson, Inc., Periscope (January 1990) (Over the next 18 months, health care costs will rise 12.5% nationally and over 22% in the Northeast United States); Division of National Cost Estimates, Health Care Fin. Admin., *National Health Expenditures, 1986-2000*, 8 Health Care Fin. Rev. 25 (1987) (By the year 2000, over \$1.5 trillion, or over 15% of GNP, will be spent on health care in the United States).

<sup>8</sup> Kalb, *Controlling Health Care Costs by Controlling Technology*, 99 Yale L.J. 1109, 1112 (1989). See also Gaul, *A Painful Lesson in the Economics of Medical Care*, Philadelphia Inquirer, April 9, 1990 at 1-D, 7-D, col. 1; Handel, *The Renewed Surge in Health Care Inflation*, Employee Benefits Digest, December 1988 at 7-8; Katz, *Fear and Trembling on the Benefits Trail*, National Underwriter Property & Casualty/Employee Benefits Edition, December 5, 1983 at 9; Adler, *Radical Changes in Benefits Loom*, Business Insurance, November 7, 1988 at 14.

<sup>9</sup> 54 Fed. Reg. 4302 (1989) (to be codified at 42 C.F.R. 400 and 405) (proposed on January 30, 1989). See Leaf, *Cost Effectiveness As a Criterion For Medicare Coverage*, 321 New Eng. J. Med. 898 (1989).

<sup>10</sup> Kittrell, *Large Employers Report More AIDS Cases: Survey*, Business Insurance, February 8, 1988 at 3.

ning. The cost of caring for AIDS patients will continue to rise as the number of people with AIDS increases,<sup>11</sup> and new and expensive forms of treatment, such as the drugs azidothymidine ("AZT") and dideoxyinosine, become available.<sup>12</sup> This financial burden is particularly acute for the Funds, as Pennsylvania ranks seventh among the states in the number of reported AIDS cases<sup>13</sup> and Philadelphia is one of the urban centers in the nation most seriously scourged by the disease.<sup>14</sup>

The national problem of substance abuse has provided a third stimulant to health care inflation. According to Nancy L. Hodes, the Executive Director of the Office of Employee Relations for the Governor of New York:

On any given day in the country, as many as 16 million employees are working under the influence

<sup>11</sup> *Estimates of HIV/AIDS and Projected AIDS Cases*, 39 Morbidity and Mortality Weekly Report (Centers for Disease Control) 110, 117 (February 23, 1990) ("AIDS cases in the United States will continue to increase through 1993").

<sup>12</sup> Marwick, *Expanding AIDS Drug Availability*, 262 J. Am. Med. Ass'n 1289 (1989); Kolata, *Many Doctors Recommend Disputed AIDS Drug*, New York Times, March 19, 1990, at B8, col. 1; Kolata, *Radically Wider Testing of AIDS Drugs is Urged*, New York Times, March 26, 1990 at A1, col. 3; U.S. *Urges Wider Use of AZT For Adults With AIDS Virus*, New York Times, March 3, 1990 at 10, col. 5; Chase, *AIDS Patients are Living Longer Now; Two Large Studies of Disease Confirm*, Wall Street Journal, January 19, 1990 at B2, col. 1; *More Workplaces Dealing With AIDS as Cases, New Treatments Increase*, 45 Daily Lab. Rep. (BNA) C-1 (March 7, 1990) ("Costs [of AIDS] are going up again because new treatments are extending the lives of patients and the drugs are expensive," according to Mark Rothstein, director of the Health Law Institute at the University of Houston).

<sup>13</sup> HIV/AIDS Surveillance Report, U.S. Dept. of Health and Human Services, Centers for Disease Control, January 1990 at 6; Report of the Pennsylvania Bar Association Task Force on Acquired Immune Deficiency Syndrome at 15 (November 11, 1989).

<sup>14</sup> HIV/AIDS Surveillance Report, *supra* note 13 at 7-8 (Philadelphia ranks sixth in number of reported AIDS cases among U.S. metropolitan areas); Lambert, *Bill to Seek \$500 Million in AIDS Disaster Funds*, New York Times, March 6, 1990 at A21, col. 2.

of illegal drugs—up to 25% of the workforce ages 20 to 40 . . . At the same time, they're driving health care costs to previously unimagined levels as they also reduce productivity and create workplace hazards for themselves and their co-workers.<sup>15</sup>

The costs resulting from this phenomenon are staggering. General Motors Corporation, for example, recently reported that "drug and alcohol abuse cost that firm \$1 billion a year."<sup>16</sup> On a nationwide basis, treatment for substance abuse now accounts for 25%-30% of the total cost of employee health care, and many experts believe that the proportion could rise to 40% in the next few years.<sup>17</sup>

Finally, government responses to the problem have often had adverse side-effects. The vast majority of states have mandated benefit laws which require insurers to provide certain benefits. These laws have inflated the cost of services by increasing patient usage of the mandated services and by encouraging providers to raise their fees once a market for the mandated services is guaranteed.<sup>18</sup>

<sup>15</sup> Hodes, *Drugs in the Workplace: New York State is Meeting the Challenge*, Employee Benefits Journal, March 1990 at 21.

<sup>16</sup> *Id.*

<sup>17</sup> Lawless, *Cost Containment Through Outpatient Substance Abuse Services*, Employee Benefits Journal, March 1990 at 6; Hastings, *Legal Developments in Managed Mental Health Care*, Physician Executive, November-December 1989 at 36 ("Between 1985 and 1987, psychiatric and substance abuse costs to employers increased 45 percent nationwide. The costs are now rising at about twice the general rate of medical inflation"); Adler, *Employers Shift Focus to Controlling Costs of Mental Health Care*, Business Insurance, February 20, 1989 at 17 "Some 20% to 25% of all employer health care expenditures go toward psychiatric and substance abuse treatment . . ."); Brostoff, *Mental Health Cost Soars, Report Says*, National Underwriter Property & Casualty/Risk & Benefits Management Edition, March 26, 1990 at 45 ("Mental health costs grew by 27 percent between 1987 and 1988" with "more than 30 million American adults suffer[ing] from some form of mental illness").

<sup>18</sup> Haistmaier, *Why America's Health Care System Is In Crisis*, Heritage Foundation Report, May 30, 1989 at 1.



Even attempts by the federal government to contain its costs have exacerbated the crisis for private employee benefit plans. For example, a recent amendment to the Social Security Act provides that all available private coverage must be exhausted before participants, or even spouses of participants, may qualify for Medicare payments.<sup>19</sup> Title VI of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, moreover, has established a series of measures designed to reduce the costs of Medicare, including new physician fee schedules. These new schedules will tend to increase Medicare fees for family practitioners and internists, while reducing Medicare fees for a variety of specialists, including surgeons, radiologists, ophthalmologists, and dermatologists. Experts believe that this new system will provide a significant challenge to employee benefit plans, because family practitioners and internists will probably raise their fees for all patients, not simply Medicare patients, while the disadvantaged specialists will attempt to recover the lost revenue from non-governmental benefit plans.<sup>20</sup>

## 2. Manifestations of the Crisis.

The seriousness of the crisis is illustrated by two remarkable developments. The first has been protracted labor strife. Approximately 60% of all strikes in the United States during 1989 were caused by disputes over health care benefits.<sup>21</sup> The most prominent of these disputes, a nine-month strike in Appalachia involving Pittston Coal Company and the United Mine Workers, required the intervention of Labor Secretary Elizabeth Dole who, on the day of settlement, announced the appointment of a

<sup>19</sup> Section 1862(b)(4) of the Social Security Act, 42 U.S.C. § 1395y(b)(4).

<sup>20</sup> Wendling and Jost, *Resource Based Relative Value Scale: A New Challenge and Opportunity for Health Care Cost Management*, Employee Benefits Journal, March 1990 at 2.

<sup>21</sup> Fisher, *Health Benefits Found Surging As Strike Issue*, National Underwriter Property & Casualty/Risk & Benefits Management Edition, March 5, 1990 at 31, col. 4.

special federal commission to study the issue of health care costs.<sup>22</sup>

The second development involves the drastic proposals for resolving the problem presented by responsible commentators. Last year, Chrysler Corporation Chairman Lee Iacocca created headlines by joining other prominent industrialists in suggesting that the proper solution may be socialized medicine.<sup>23</sup> In March 1990, the United States Bipartisan Commission on Comprehensive Health Care, a panel appointed by President Reagan in 1988 and commonly called the "Pepper Commission," advocated a system of universal health coverage which would cost \$86 billion dollars. Of this figure, \$66.2 billion would be provided by the federal government and \$20 billion by private sources.<sup>24</sup> Even the normally conservative American Medical Association has proposed a system of national health insurance which closely resembles the recommendations of the Pepper Commission.<sup>25</sup> On the other extreme, the *Wall Street Journal* has tacitly endorsed taxing health care benefits, on the ground that forcing individuals to pay a greater percentage of medical

<sup>22</sup> Kilborn, *Dole Winning Applause for Labor Department Actions*, New York Times, January 4, 1990 at 16, col. 1. See also Verespej, *Rx For Costs Elusive*, Industry Week, December 4, 1989 at 88.

<sup>23</sup> Nelson-Hurchler, *U.S. Catching Socialism?*, Industry Week, August 21, 1989 at 45.

<sup>24</sup> U.S. Bipartisan Comm'n on Comprehensive Health Care (Pepper Comm'n), *Recommendations to the Congress*, March 2, 1990 at 18-21; The Wyatt Company, *Pepper Commission Suggests \$86 Billion Health Plan*, The Compensation and Benefits File, March 1990 at 1.

<sup>25</sup> Wagner, *A.M.A. Proposes National Healthcare Reform Plan*, Modern Healthcare, March 12, 1990 at 2; *A.M.A. Urges Broad Health Plan*, New York Times, March 8, 1990 at B9; Locke, *AMA Seeks Employer Mandate*, Business Insurance, March 12, 1990 at 102.



bills will drive costs down by causing the public to conserve.<sup>26</sup>

**B. To Deal With the Health Care Crisis, the Funds Must Either Cut Costs or Reduce the Amount of Available Benefits.**

Multiemployer plans cannot remain on the sidelines while the merits of the various proposals for reform are debated. Employees and their dependents need adequate health care on an on-going basis. As previously indicated, multiemployer benefit plans have no power to raise their contribution levels to meet the current waive of health care inflation. Therefore, the Trustees of such plans are between Scylla and Charybdis—they must either cut costs or reduce the amount of assets available for benefits. There is no other alternative.

**C. An Effective System of Cost Containment Requires Elimination of Unnecessary and Duplicative Expenditures.**

Experts unanimously agree that, to cut costs, benefit plans must limit needless and redundant expenditures by adopting programs such as: (1) a centralized record system to avoid repetitive diagnostic testing, (2) second opinion and utilization review programs, to prevent needless treatment, (3) increased resort to less costly treatment options, *e.g.*, outpatient care, (4) education of participants to help them avoid sickness, (5) establishment of networks of selected physicians who provide efficient treatment, and (6) direct negotiations with health providers such as hospitals, druggists, and physicians, in order to cut prices through volume discounts, preferred provider organization arrangements, and *per diem* contracts.<sup>27</sup>

<sup>26</sup> *Markets and Medical Costs*, Wall Street Journal, April 11, 1990 at A 14, col. 1.

<sup>27</sup> *E.g.*, Lawless, *supra* note 17 at 6; Feldstein, Wickizer & Wheeler, *Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 New Eng. J. Med.

**II. THE THIRD CIRCUIT'S DECISION CONSTITUTES A DIRECT THREAT TO EFFECTIVE COST CONTAINMENT AND, THUS, WOULD COMPROMISE THE WELL-BEING OF ALL PERSONS WHO RECEIVE THEIR HEALTH CARE FROM THE FUNDS OR SIMILARLY-SITUATED BENEFIT PLANS.**

**A. The Third Circuit's Ruling Would Drastically Limit the Right of the Funds to Contain Costs Through Subrogation.**

The subrogation provisions at issue in this case are a form of cost containment. Their goal is to limit "double dipping."

This concept is hardly radical. The Funds' subrogation policy is highly analogous to "coordination of benefits," a practice which prevents duplicative compensation by prorating benefit payments between or among different insurers or benefit plans. The right to coordinate benefits is well-recognized in the context of insurance law. 8A Appleman, *Insurance Law and Practice* §§ 4906-010, at 341-492 (1981); 16 Couch on Insurance 2d (Rev. ed.) §§ 62.41-62.188, at 475-657 (1983). Coordination should be even more appropriate for self-insured ERISA plans, where the savings translate into benefits for other employees, as opposed to increased profits for insurance companies.<sup>28</sup> The only distinction between coordination of

1310 (1988); Sizemore, *Concerns on Cost Lead to Innovation*, Pension & Benefits, Fall 1989 at 13; Haggerty, *Direct Health Contracting Curbs Costs—Consultant*, National Underwriter Property & Casualty/Employee Benefits Edition, May 22, 1989 at 21; Cave, *Direct Contracting With Hospitals: Alternative Payment Arrangements*, Employee Benefits Journal, June 1989 at 26; Ozzie and Harriet Package of Employee Benefit Funds, Chicago Tribune, January 1, 1989 at 37; Gannes, *Strong Medicine for Health Bills*, Fortune, April 13, 1987 at 70; Gaul, *How 3 Companies Hold the Line on Health Costs*, Philadelphia Inquirer, April 9, 1990 at 1-D, col. 2.

<sup>28</sup> Ironically, the Third Circuit is the only court which has considered the extent to which coordination of benefits is applicable to ERISA. In *Northeast Department ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147 (3d Cir. 1985), the court indicated that coordination of benefits provisions are valid as long as they do not cause a participant

benefits and the Funds' subrogation policy is that the latter reduces expenditures in accordance with the amount paid by tort-feasors, rather than the amount provided by other benefit plans. The end result is the same, *i.e.*, more assets for other participants and beneficiaries.

If the Third Circuit's position remains intact, the Funds will be compelled to pay out hundreds of thousands, perhaps millions, of dollars to "double dipping" participants and beneficiaries whose claims stem from automobile accidents.<sup>29</sup> Such a torrent of needless and duplicative payments would directly reduce the amount of money available for benefits and would thereby contradict ERISA's avowed goal to safeguard such benefits.

**B. New Legislation in Pennsylvania Threatens to Magnify the Adverse Impact of the Third Circuit's Decision Upon the Funds.**

Under the Pennsylvania statute which existed at the time of the Third Circuit's decision, no fault automobile

to receive less than he or she would receive in the absence of alternate coverage. *Id.* at 161-62 n.13. The Funds' subrogation provisions, which only seek to prevent or recoup payments actually received from another source, would clearly pass muster under this test.

<sup>29</sup> The exact amount which subrogation saves benefit plans varies with time, depending upon the number of accidents, the size of the recoveries, and the solvency of the tort-feasors. *Holliday*, for example, is a case where the tort-feasor had limited insurance coverage and an obligation to pay multiple plaintiffs. Nevertheless, the plan could have saved approximately \$50,000 through subrogation. Thus, only a handful of accidents of this type can involve hundreds of thousands of dollars.

The amount at issue on a national basis is staggering. In 1985, the lifetime cost of medical and disability benefits arising from motor vehicle injuries in the United States amounted to \$48,683,000,000. Rice & MacKenzie, *Cost of Injury in the United States: A Report to Congress*, at 44 (1989). Figures are not available for subsequent years. Estimating an annual rate of increase at 10%, the figures would be \$53,551,300,000 in 1986; \$58,906,430,000 in 1987; \$64,797,073,000 in 1988; \$71,276,780,000 in 1989; and \$78,404,458,000 in 1990. These figures are conservative in light of the roaring rates of inflation currently experienced in health care.

insurance policies were required to provide a minimum medical benefit of \$10,000. 75 Pa. C.S.A. § 1711 (Purdon 1989). An employee benefit plan's obligation to compensate was not triggered until that sum was expended. 75 Pa. C.S.A. § 1719 (Purdon 1989); *see also FMC Corp. v. Holliday*, 885 F.2d at 81-83.

In February 1990, the Pennsylvania legislature enacted a series of amendments to the Motor Vehicle Financial Responsibility Law. The anti-subrogation provision remained fully effective.<sup>30</sup> The minimum automobile insurance medical benefit, conversely, was reduced to \$5,000.<sup>31</sup> Furthermore, while the prior version of the statute contained an allowance for lost income—which the Funds provide in the form of disability benefits—that component was eliminated in the current statute.<sup>32</sup>

If these amendments are sustained, their net effect under the opinion below would be a substantial increase in the financial obligations of self-insured ERISA plans which operate in Pennsylvania.<sup>33</sup> The reason for this increased liability is simple. The amendments would require ERISA funds to pay, without the benefit of subrogation, all but the first \$5,000 (rather than \$10,000) of medical benefits and all lost income arising from automobile accidents. These increased expenditures, in turn, would reduce the assets available for employees who do not "double dip."

<sup>30</sup> Compare 75 Pa. C.S.A. § 1720 (Purdon 1989) with Pa. H.R. Bill No. 121, 1990 Sess., Section 9 at 31 (signed into law February 7, 1990) (amendment to 75 Pa. C.S.A. § 1720).

<sup>31</sup> See Pa. H.R. Bill No. 121, 1990 Sess., Section 9, at 27-28 (signed into law February 7, 1990) (amendment to 75 Pa. C.S.A. § 1711).

<sup>32</sup> *Id.*

<sup>33</sup> Fish, *How Drivers Would Save Under the Insurance Plan*, Philadelphia Inquirer, February 6, 1990 at 4-A, col. 1.



**C. The Third Circuit's Decision Threatens to Subject the Funds, and Other Self-Insured Benefit Plans, to Unfettered State Interference With Cost Containment Policies.**

The challenge to sound cost containment policy is not limited to the specific mechanism of subrogation. According to the Third Circuit, state insurance laws are only preempted to the extent that they involve "core" ERISA concerns. *FMC Corp. v. Holliday*, 885 F.2d at 88. While the Third Circuit's definition of "core" is murky, the very holding of *Holliday* excludes cost containment measures, such as subrogation, from "core" concerns. This relaxed definition of ERISA preemption is very significant, because many cost containment measures are presently under siege in state courts and legislatures.

This siege is motivated by economics. Cost containment causes "a loss of revenue to health care providers."<sup>34</sup> Health care providers, in turn, have counterattacked, often resorting to state law.

Pennsylvania, for example, is experiencing an assault upon the ability of benefit plans to negotiate exclusive dealing arrangements with certain pharmacists in exchange for volume discounts. As previously explained, arrangements of this nature are strongly recommended by experts in the health field as an effective means for maximizing an ERISA plan's purchasing power.<sup>35</sup> A lobbying group for druggists named the Pennsylvania Pharmaceutical Association has proposed legislation to prevent insurance companies and ERISA plans from negotiating such contracts. This legislation has broad support.<sup>36</sup> If the legislation passes and is challenged on the basis of ERISA preemption, the pharmacists would certainly cite *Holliday* for the proposition that cost containment measures are not "core" ERISA concerns. Suc-

<sup>34</sup> Handel, *supra* note 8, at 7.

<sup>35</sup> See *supra* note 27, and accompanying text.

<sup>36</sup> Benson, *Pharmacy Bill Would Target Private Pacts*, Pittsburgh Business Times & Journal, June 19, 1989 at 15.

cess on such an argument would rob the Funds of another important method to contain costs.

Similarly, in *Varol v. Blue Cross & Blue Shield*, 708 F. Supp. 826 (E.D. Mich. 1989), a group of physicians argued that Michigan law prohibited a variety of widely-recognized procedures crafted to prevent unneeded or duplicative medical procedures, *e.g.*, preauthorization and concurrent utilization reviews. The court ruled against the physicians on the ground that ERISA preempted the state law in question. The Third Circuit's analysis, however, could lead to a contrary result. In that event, the physicians' lobby would pose an additional threat to the Funds and other self-funded benefit plans.<sup>37</sup>

Yet lawyers probably pose the most potent threat to cost containment. The hostility of the plaintiff's bar to certain forms of cost containment is demonstrated by the various *amicus curiae* briefs which the Pennsylvania Trial Lawyer's Association has filed in support of the *Hollidays*, both in the Third Circuit, 885 F.2d at 85, and in this Court. Trial lawyers, moreover, are a powerful political force on the state level. In Pennsylvania, for example, they have played a major role in shaping automobile insurance laws, the source of the "double dipping" provision which gave rise to this litigation.<sup>38</sup>

<sup>37</sup> As this brief was in its final stages of preparation, the Pennsylvania Medical Society and several allied groups obtained an injunction in the Pennsylvania Commonwealth Court which precluded enforcement of certain aspects of the state no-fault law which placed limits on medical costs. Enda, *Again, It's No Go for Pa. Car Law*, Philadelphia Inquirer, April 17, 1990 at 1, col. 1. This litigation further demonstrates the medical profession's political power and opposition to cost containment. See Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. Pa. L. Rev. 431, 536 (1988) (noting that, as a group, physicians are hostile to cost containment programs and "will use every weapon in their considerable arsenal to defend" against such policies).

<sup>38</sup> Cohn, Fish & Enda, *How Interest Groups Mold Pa.'s Auto Insurance System*, Philadelphia Inquirer, October 23, 1989 at 1-A, col. 1. ("[T]oday, as in 1983 [when the current automobile legis-



Congress fashioned ERISA to prevent encroachment from professional interest groups. During the legislative debate on ERISA, Senator Williams discussed preemption while delivering the report of the Conference Committee to the full Senate. As a floor manager of ERISA, his comments merit great weight. Senator Williams asserted that "[s]tate professional organizations acting under the guise of state-enforced professional regulation, should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized." 120 Cong. Rec. 23,933 (1974). Significantly, the Third Circuit's opinion recognized the foregoing statement as an accurate expression of the Congressional intent underlying ERISA. 885 F.2d at 87. This recognition is ironic since the logic of the opinion below would place self-funded ERISA plans at the mercy of state laws enacted or invoked by "state professional organizations."<sup>39</sup>

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lation was enacted] a large part of the decision-making process has fallen under the influence of . . . the trial lawyers who profit tremendously from the state's insurance system"); Statement of State Representative Andrew J. Carn, PR Newswire, January 10, 1990 (available on NEXIS) (identifying the Pennsylvania Trial Lawyers Association as one of the organizations which "wrote the present laws governing auto insurance in . . . Pennsylvania").

<sup>39</sup> The traditional professions are not the only source of opposition to independent cost containment. State bureaucrats have a tendency to expand their power at the expense of self-funded plans. Such an effort has already been made in Pennsylvania.

In *Insurance Board of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987), the Pennsylvania State Insurance Commissioner argued that the administrator of a self-funded ERISA plan fell within the jurisdiction of his department and, thus, was subject to all state laws concerning benefits. Had the Commissioner succeeded, the independence of such plans in benefit or cost containment matters would have been shattered. The Third Circuit rejected the Commissioner's argument, reasoning that an independent administrator is not engaged in the business of insurance and, thus, is not affected by the "savings clause" which preserves state insurance laws from ERISA preemption. 819 F.2d at 413.

*Holliday* indicates that the Third Circuit will not apply *Muir* when a party invokes a state insurance law directly against a plan,

In summary, the Third Circuit's decision threatens the integrity of the Funds' cost containment efforts and their independence from special interest groups. Consequently, the Funds have submitted this brief as *amici curiae*. The parties have consented to the Funds' appearance in this capacity, and copies of letters memorializing that consent have been filed with the Court.

### SUMMARY OF ARGUMENT

The decision below should be reversed for three independent reasons. First, the Third Circuit's conclusion that the "deemer clause" of ERISA only protects "core" ERISA concerns is patently erroneous. The indicia of legislative intent, especially the evolution of the overall statutory scheme, demonstrate that Congress intended to insulate self-insured employee benefit plans from state legislation such as that involved in this case.

Second, the decision below would lack merit even if the Third Circuit were correct in concluding that the shield of the deemer clause is limited to "core" ERISA matters. Subrogation is designed to help effectuate the obligation of ERISA fiduciaries to preserve trust assets for the benefit of those who rely upon the benefit plan in question. By impairing these cost containment efforts, Pennsylvania has violated the "core" concerns of ERISA.

Third, the Pennsylvania statute is preempted irrespective of this Court's interpretation of the deemer clause. Subrogation is an equitable remedy which retains its vitality in the context of ERISA, by providing a means to conserve trust assets. Since the remedy is not limited to the insurance industry, state laws which relate to it are not rescued from preemption by the savings clause.

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as opposed to an independent administrator. Hence, if the Third Circuit's decision in *Holliday* is not reversed, it may provide a basis for state domination of self-insured funds.

## ARGUMENT

### I. THE "DEEMER CLAUSE" OF ERISA, WHICH MUST BE READ IN CONJUNCTION WITH THE PERIODIC PAYMENT SETTLEMENT ACT OF 1982, CLEARLY INSULATES SELF-INSURED EMPLOYEE BENEFIT PLANS FROM STATE INSURANCE LAWS.

The Third Circuit's analysis in this case was three-pronged. First, the court found that the state statutory ban on subrogation was preempted by ERISA § 514(a), 29 U.S.C. § 1144(a). Second, the Third Circuit concluded that the "savings clause" of ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), exempted the case from ERISA preemption, because the Pennsylvania statute regulated insurance. Third, the court found that the "deemer clause" of ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), did not reestablish preemption.

The Third Circuit's construction of the deemer clause confronted a significant obstacle. This Court's unanimous opinion in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) specifically recognizes "a distinction between insured and uninsured [*i.e.*, self-insured] plans, leaving the former open to indirect regulation while the latter are not." Instead of following *Metropolitan Life Insurance*, the Third Circuit rather condescendingly dismissed this Court's interpretation of the deemer clause as "dicta" supported by "neither statutory text nor legislative history." 885 F.2d at 89. In so doing, the Third Circuit committed a fundamental error.

As a preliminary matter, the discussion of ERISA preemption in *Metropolitan Life Insurance* is not an off-hand comment which a court of appeals may cavalierly dismiss. The *Metropolitan Life Insurance* opinion turns on a detailed analysis of ERISA preemption, including the legislative history re-sifted by the Third Circuit. Compare *Metropolitan Life Insurance*, 471 U.S. at 745-747 with *Holliday*, 885 F.2d at 86-89. In effect, the

Third Circuit has repudiated this Court's careful interpretation of the deemer clause.

Furthermore, for all its apparent concern with legislative history and the underlying intent of Congress, the Third Circuit ignored the effect of an integral amendment to the deemer clause enacted by the Periodic Payment Settlement Act of 1982, Pub. L. No. 97-473 ("PPSA"), codified at § 514(b)(5) of ERISA, 29 U.S.C. § 1144(b)(5). The PPSA provides that the preemption provisions of ERISA "shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51)."<sup>40</sup> The establishment of this explicit exception for Hawaii illustrates the full breadth of preemption which applies to other states, such as Pennsylvania.

The PPSA must be read in light of two significant Ninth Circuit cases which preceded it. In *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978), the Ninth Circuit held that a California statute was preempted to the extent that it affected a self-insured employee benefit plan. The court explained that "[a]lthough Section 514(b)(2)(A) exempts from preemption state regulation of insurance, Section 514(b)(2)(B) provides that *employee benefit plans may not be considered to be in the business of insurance for purposes of the exception to preemption*." 571 F.2d at 504 (emphasis added). In short, *Hewlett-*

<sup>40</sup> The text of the exemption for Hawaii law established by the PPSA states, in relevant part:

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.



*Packard* anticipated this Court's opinion in *Metropolitan Life Insurance* by concluding that the deemer clause exempts self-funded plans from state insurance law. This position, of course, flatly contradicts the Third Circuit's holding below.

One year after *Hewlett-Packard*, the Ninth Circuit considered the affect of ERISA preemption upon the Hawaii Prepaid Health Care Act, which required employers doing business in Hawaii to furnish employees with certain mandated benefits. Standard Oil of California, which maintained a self-funded plan for its employees in that state, brought a declaratory judgment action, arguing that the Hawaiian legislation was preempted by ERISA. Citing *Hewlett-Packard*, the Ninth Circuit agreed that the state statute was preempted. *Standard Oil of California v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1979), *summarily aff'd*, 454 U.S. 801 (1981). Hawaii then sought relief in Congress.

On October 1, 1982, Senator Robert Dole of Kansas reported the PPSA to the Senate on behalf of the Finance Committee. He noted that the bill "includes four provisions, each of merit and I believe noncontroversial." Senator Dole then introduced Senator Spark Matsunaga of Hawaii who discussed one of these provisions, *i.e.*, "a committee amendment which rescues the Hawaii Health Care Act from preemption by the Employment Retirement Income Security Act of 1974." 128 Cong. Rec. 26,902 (1982). Senator Matsunaga discussed the *Agsalud* litigation, describing the ultimate judicial determination that "the broad language of ERISA preempted all state law relating to private employee benefit plans including Hawaii's Prepaid Health Insurance Act." 128 Cong. Rec. 26,903 (1982). He noted that, in 1979, Congress had failed to pass a bill designed "to exempt from preemption state health insurance law" throughout the nation, and that opponents of the *Agsalud* decision had then limited their efforts to exempting "only the Hawaii statute." Without further debate, the Senate passed the bill unanimously.

On December 13, 1982, Congressman Dan Rostenkowski of Illinois introduced the PPSA to the House of Representatives. He noted that the House Committee on Education and Labor had amended the Senate's Hawaiian exemption by including language "to the effect that the exception made by this legislation is not to be considered a precedent for extending the exception to other state laws." 128 Cong. Rec. 30,352 (1982). Congressman John Erlenborn of Illinois then made the only significant speech on the Hawaiian proviso, in which he stated:

Last year the Supreme Court let stand the decision of the Ninth Circuit Court of Appeals in *Standard Oil of California* against *Agsalud* that the broad preemptive framework relating to pension and welfare (for example, health) plans agreed to by the ERISA conferees does in fact supersede the Hawaii statute. *The agreement to amend ERISA to permit the future application of the Hawaii law was reached solely on the basis and with the understanding that the Hawaii law is an unusual special case, inasmuch as the law was enacted just prior to the signing of ERISA on September 2, 1974, and that the law will be permitted to operate only as a narrow exception which is not expected to do violence to the strong Federal preemption scheme. In agreeing to the Hawaii exception this body will be reaffirming the broad scope of ERISA preemption and the validity of the interpretation of the Federal courts in connection with the Hawaii statute.* To help allay the fears of those who might otherwise view this action as the beginning of a weakening of Federal preemption under ERISA, *the amendment contains an explicit statement that this limited exception shall not be considered a precedent with respect to extending similar treatment to any other State law.*

128 Cong. Rec. 30,356 (1982) (emphasis added).

The bill was then referred to the Conference Committee to reconcile the difference caused by the House amendment, which emphasized that this special provision would not serve as a precedent for any further state law



exemptions. The Committee recommended the House version, which was then enacted into law.<sup>41</sup> 128 Cong. Rec. 33,183, 33,236; 33,240; 33,263; 33,433 (1982).

Read together, the deemer clause and the PPSA were intended to insulate self-insured ERISA plans which do not operate in Hawaii from regulation under state insurance laws. Thus, Pennsylvania's statutory ban on subrogation cannot apply to such plans.

The appropriateness of interpreting the deemer clause in light of the PPSA cannot be disputed. This Court has repeatedly recognized that "[s]ubsequent legislation declaring the intent of an earlier statute is entitled to great weight in statutory construction." *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 380-81 (1969). *Accord*, *Seatrains Shipbuilding Corp. v. Shell Oil Co.*, 444 U.S. 572, 595-596 (1980); *FHA v. The Darlington, Inc.*, 358 U.S. 84, 90 (1958). That principle is especially persuasive when a legislative amendment ratifies all or part of a prior judicial or administrative interpretation of the original statute. *NLRB v. Bell Aerospace Co.*, 416 U.S. 267 (1974); *Red Lion Broadcasting*, *supra*, 395 U.S. at 381-82.

This Court, moreover, has explicitly recognized that *Agsalud* is very relevant to interpreting the scope of ERISA preemption especially because the Ninth Circuit's decision was summarily affirmed. According to

<sup>41</sup> The full text of the House amendment to the Hawaiian exception stated, "The amendment made by this section shall not be considered a precedent with respect to extending such amendment to any other State law." The amendment was eventually codified at § 301 of Pub. L. No. 97-473 and the notes to 29 U.S.C. § 1144.

The exception has been interpreted narrowly. Since Congress only excepted the "substantive provisions [of the Hawaii statute] in effect on September 2, 1974." 29 U.S.C. § 1144(b)(5)(B)(ii), the exemption does not cover collectively bargained plans, which the Hawaiian legislation did not attempt to regulate until 1978. *Council of Hawaii Hotels v. Agsalud*, 594 F. Supp. 449, 455-56 (D. Haw. 1984). Thus, Taft-Hartley plans—such as the Funds—cannot be regulated by state law, even in Hawaii.

*Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), state laws which affect the benefit structure of self-insured ERISA plans are preempted for the following reasons:

*Agsalud* . . . illustrates that whether a State requires an existing plan to pay certain benefits, or whether it requires the establishment of a separate plan where none existed before, the problem is the same. Faced with the difficulty or impossibility of structuring administrative practices according to a set of uniform guidelines, an employer may decide to reduce benefits or simply not to pay them at all.

482 U.S. at 12-14.

There is no dispute that the FMC Plan, like each of the Funds, is a *bona fide* ERISA plan. If the Third Circuit's decision were to stand, ERISA plans would become subject to a wide variety of intrusive and conflicting state laws.<sup>42</sup> These state laws would mandate the payment of benefits (including *duplicative* payments) in numerous situations. As demonstrated by *Fort Halifax* and earlier portions of this brief, the end result would be an incentive, and in some cases a necessity, "to reduce benefits or simply not to pay them at all." To avoid that untoward result, the decision below must be reversed.

## II. THE DECISION BELOW SHOULD BE REVERSED EVEN IF THIS COURT WERE TO FIND THAT THE DEEMER CLAUSE ONLY PROTECTS "CORE" ERISA CONCERNS.

The Third Circuit's decision springs from the conclusion that the deemer clause only shields "core" ERISA concerns. Perhaps the most vivid defect in this fallacy is the fact that the Third Circuit had to invent the term "core," which is not used in ERISA, has no textual basis

<sup>42</sup> Although the Funds are based in Pennsylvania, their jurisdiction extends to other states. For example, the Teamsters Health and Welfare Fund of Philadelphia & Vicinity has thousands of participants in Delaware and New Jersey. The petitioner's brief, moreover, demonstrates that the FMC Plan is national in scope.

in the relevant legislative history, and does not even have an apparent definition in this context. Yet whatever "core" may mean, the Third Circuit certainly intended it to involve matters of critical importance. Any other definition would do violence to the English language.<sup>43</sup> Judged by this standard, Pennsylvania's constraints upon subrogation clearly impair "core" ERISA concerns, arising from fiduciary obligations at the heart of the statute.

**A. ERISA's "Core" Concerns Include the Fiduciary Obligations of Trustees to Preserve and to Maximize the Productivity of Plan Assets.**

In enacting ERISA, Congress declared that the "financial soundness" and "equitable character" of employee benefit plans are critically important to the national interest. 29 U.S.C. 1001(a). Consistent with this finding, ERISA codifies many principles of trust law designed to protect plans, including the requirements that: (1) all assets (except those which consist of insurance contracts or policies) of employee benefit plans be held in trust, 29 U.S.C. § 1103(a), and (2) the individuals who manage such plans be fiduciaries bound by duties of exclusive loyalty and prudence. Furthermore, "rather than explicitly enumerating *all* of the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility." *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1985) (emphasis in original, footnote omitted). *Accord, Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948, 954-55 (1989).

At common law, trustees have several well recognized duties which are particularly relevant to ERISA. First, a trustee must "use reasonable care and skill to preserve the trust property." Restatement (Second) of Trusts

<sup>43</sup> The definitions of the adjective "core" are: "a: a basic, essential, or enduring part (as of an individual, a class, or an entity) b: the essential meaning: GIST . . . c: the inmost or most intimate part." *Webster's New Collegiate Dictionary*, 250 (1973).

§ 176 (1959). Second, a trustee must "take reasonable steps to realize on claims which he holds in trust." Restatement (Second) of Trusts § 177 (1959). Third, a trustee has an obligation "to use reasonable care and skill to make the trust property productive." Restatement (Second) of Trusts § 181 (1959). *Accord*, 2A Fratcher, Scott on Trusts, §§ 176, 177 & 181 (4th ed. 1987).

The appropriateness of these rules in the context of ERISA is virtually self-evident, as they all support the "financial soundness" and "equitable character" of benefit plans. Their importance increases geometrically when viewed in context of the current national health care crisis. As explained above, expert opinion unanimously agrees that efforts to make the best use of plan assets must be redoubled in order to deal with spiraling inflation.

**B. The Pennsylvania Statute Interferes With Trustees' Ability to Adhere to Their "Core" Fiduciary Obligations.**

By adopting and enforcing subrogation policies, trustees of employee benefit plans comply with their fiduciary obligations. Every dollar saved through prevention of "double dipping" translates into an additional dollar available for actual treatment. The large volume of litigation engendered by the subrogation issue and the number of *amici curiae* which support reversal of the Third Circuit demonstrate that fiduciaries across the nation believe that subrogation is an important cost containment measure.

Conversely, the Pennsylvania anti-subrogation statute legislates a waste of plan assets, and thereby flouts the whole purpose of ERISA. It is difficult to conceive of a more fundamental clash between federal and state legislation. In every sense of the word, the Pennsylvania legislature has tread upon the very "core" of ERISA. Hence, the decision below cannot stand even if this Court adopts the Third Circuit's analytical framework.



### III. THE "SAVINGS" CLAUSE OF ERISA DOES NOT PRESERVE THE PENNSYLVANIA ANTI-SUBROGATION STATUTE FROM PREEMPTION.

*Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987) sets forth the test for applying the savings clause. The precise issue in *Pilot Life* was whether ERISA preempted Mississippi tort laws which created causes of action for bad faith denial of benefits. The defendant-plan was financed by a policy purchased from an insurance company. The plaintiff argued that the state law remedies regulated insurance, and, thus, were preserved by the savings clause. This Court disagreed and found preemption.

*Pilot Life* utilized a two-part test. First, the Court considered whether a "common-sense view" of the savings clause indicated that the state law in question should be preempted. The second was whether the state law applied to the "business of insurance," as that term is used in the McCarran-Ferguson Act, 15 U.S.C. §§ 1101-015. 481 U.S. at 48-49. The Pennsylvania anti-subrogation statute cannot survive either test.

#### A. Preemption is Appropriate Under the "Common-Sense" View of the Savings Clause.

The "common-sense" analysis turns on whether the historical roots of the state law in question arise from matters peculiar to the insurance industry. If not, then the savings clause does not apply.

The Mississippi torts at issue in *Pilot Life* dated to the early part of the twentieth century, when a series of state supreme court cases created a tort remedy for intentional breach of contract. Although the torts were most often asserted in connection with improper denial of benefits under an insurance contract, they were applicable to the intentional breach of other types of contracts. This fact was dispositive. According to *Pilot Life*:

A common-sense view of the word "regulates" would lead to the conclusion that in order to regulate in-

surance, a law must not just have an impact on the insurance industry, *but must be specifically directed toward that industry*. Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, *the roots of this law are firmly planted in the general principles of Mississippi tort and contract law*. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law.

481 U.S. at 50 (emphasis added).

The savings clause is even less applicable to this case than it was to *Pilot Life*. Subrogation is much older than the insurance industry, dating back to Roman times. 73 Am. Jur. 2d Subrogation § 5 at 601-02 (1964).<sup>44</sup> Although the right to subrogate is commonly asserted by insurers, it is not so limited because, as a creature of equity,<sup>45</sup> the right can be invoked whenever necessary to prevent injustice. Restatement of Restitution § 162 (1937).

This Court, moreover, has recognized subrogation in non-insurance matters. *Prairie State Bank v. United States*, 164 U.S. 227, 231 (1896) (subrogation could be asserted by the surety of a government contractor); *Memphis & Little Rock Railroad v. Dow*, 120 U.S. 287, 302 (1887) (trustees of mortgaged property entitled to subrogation in order to recover legal expenses incurred in defending mortgaged property against lien asserted by the state).

<sup>44</sup> As Chief Justice Vanderbilt explained on behalf of the court in *Standard Accident Insurance Co. v. Pellecchia*, 15 N.J. 162, 171, 104 A.2d 288, 292 (1954), subrogation "is a right of ancient origin, having been imported from the civil law to serve the interests of essential justice between the parties."

<sup>45</sup> *Aetna Life Insurance Co. v. Middleport*, 124 U.S. 534, 549 (1888).



In contrast to the Third Circuit, the Eighth Circuit has held that state laws which impair the subrogation rights of ERISA plans are not saved from preemption by a "common-sense reading" of the savings clause. In *Baxter v. Lynn*, 886 F.2d 182, 186 (8th Cir. 1989), the court held that while "the law of subrogation is generally applicable to insurance contracts, it is not specifically directed toward the insurance industry." The foregoing authorities demonstrate that the *Baxter* analysis is correct and should be adopted by this Court.

**B. The Pennsylvania Anti-Subrogation Statute Does Not Regulate the "Business of Insurance" Within the Meaning of the McCarran-Ferguson Act.**

The McCarran-Ferguson Act creates a limited exemption for the "business of insurance" from the federal antitrust laws. This Court has construed the exemption narrowly. Measures to cut costs and maximize efficiency of operations do not constitute the "business of insurance," even when effected by insurance companies. Hence, the subrogation policies at issue in this case could not conceivably fall within McCarran-Ferguson, especially in the context of self-insured plans.

In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), a group of pharmacists sued an insurance company, Blue Shield, under the antitrust laws. Blue Shield had secured substantial volume discounts for drug purchases by negotiating agreements with pharmacists throughout Texas. When the plaintiffs alleged that the practice amounted to price-fixing and a group boycott, Blue Shield countered that the disputed practice constituted the "business of insurance" and, thus, was exempt under McCarran-Ferguson. This Court disagreed with Blue Shield, noting that "[t]he primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk." According to *Royal Drug*:

The Pharmacy Agreements . . . do not involve any underwriting or spreading of risk, but are

merely arrangements for the purchase of goods and services by Blue Shield. By agreeing with pharmacies on the maximum prices it will pay for drugs, *Blue Shield effectively reduces the total amount it must pay to its policyholders*. The Agreements thus enable Blue Cross to minimize costs and maximize profits. Such cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."

440 U.S. at 214 (emphasis added). Accord, *United Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982) (utilization review procedure); *Baxter v. Lynn*, 886 F.2d at 186 (subrogation).

The Third Circuit would give cost containment the worst of all worlds, denying both the McCarran-Ferguson antitrust exemption and ERISA preemption. That result would controvert the will of Congress, flout the precedents of this Court, and, in view of the importance of sound cost containment to the health care system, disserve the interests of all American workers and their families.

### CONCLUSION

For the foregoing reasons, the opinion of the Third Circuit should be reversed.

Respectfully submitted,

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IN THE  
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OCTOBER TERM, 1989

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*Petitioner,*  
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CYNTHIA ANN HOLLIDAY,  
*Respondent.*

On Writ of Certiorari to the United States  
Court of Appeals for the Third Circuit

BRIEF OF THE NATIONAL COORDINATING  
COMMITTEE FOR MULTIEMPLOYER PLANS AS  
AMICUS CURIAE IN SUPPORT OF PETITIONER

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BRIEF OF THE NATIONAL COORDINATING  
COMMITTEE FOR MULTIEMPLOYER PLANS AS  
AMICUS CURIAE IN SUPPORT OF PETITIONER

---

**PRELIMINARY STATEMENT**

The National Coordinating Committee for Multiemployer Plans ("NCCMP") submits this brief *amicus curiae*<sup>1</sup> to urge the Court to reverse the holding below.

Contrary to an express mandate of Congress and previous rulings of this Court, the ruling of the Third Circuit, if not reversed, will give a preemptive effect to state automobile insurance statutes and presumably to other state insurance laws as well. The ruling will therefore inhibit the trustees of multiemployer employee benefit plans from designing cost-containment strategies to protect and improve the financial soundness of the

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<sup>1</sup> Letters manifesting the consent of Petitioner and Respondent have been filed with the Clerk of the Court.



plans (such as subrogation and coordination of benefits) and bar them from implementing such strategies through enforcement of their plan documents in any state in which the plan provisions, though consistent with ERISA and with federal employee benefits policy, are found to be inconsistent with local insurance law.

By enacting ERISA, Congress sought to enhance the financial stability of multiemployer plans and to foster the growth and maintenance of such plans. 29 U.S.C. § 1001. The NCCMP files this brief because the decision below is contrary to those goals.

### INTEREST OF THE NCCMP

The NCCMP is a nonprofit, tax-exempt organization that was formed after enactment of the Employee Retirement Income Security Act of 1974,<sup>2</sup> 29 U.S.C. § 1001 *et seq.* ("ERISA"), to participate in the development of employee benefits legislation, government regulations promulgated to implement ERISA, and other laws affecting multiemployer plans. Currently, more than 190 multiemployer plans and related international unions, located in at least 37 states, are affiliated with the NCCMP. These plans are representative of all of the nation's multiemployer plans which cover more than nine million workers. The decision below has far-reaching adverse consequences for all multiemployer plans and, therefore, is particularly adverse to the interests of NCCMP affiliates which represent the majority of participants in such plans.

Because of the broad range of experience of the NCCMP's constituent organizations and its close ongoing

<sup>2</sup> ERISA was amended in 1980 by the Multiemployer Pension Plan Amendments Act of 1980, Pub. L. 96-364, 94 Stat. 1208 (1980). The NCCMP has been recognized as having had a "significant impact" on this statute by the Senate cosponsors of that legislation. See 126 Cong. Rec. S9835 (daily ed., July 24, 1980) and S10100 (daily ed., July 29, 1980).

contacts with hundreds of trustees charged with the administration of multiemployer plans in accordance with ERISA's fiduciary duty rules and principles, the NCCMP believes that it is qualified to provide the Court with insight into the practical implications of the decision below for multiemployer plans and to state the position of the trustees, participants, and beneficiaries of such plans. In fact, the NCCMP has recently participated as an *amicus curiae* in *Connolly v. PBGC*, 475 U.S. 211 (1986); *Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559 (1985); *PBGC v. R.A. Gray & Co.*, 467 U.S. 717 (1984); and *Jim McNeff, Inc. v. Todd*, 461 U.S. 260 (1983).

In the decision below, the Court of Appeals for the Third Circuit, departing from the text of ERISA's preemption provision, 29 U.S.C. § 1144, as well as its construction by this Court, courts of appeals of the majority of other circuits, and numerous district courts, ruled that Petitioner FMC Corporation, a self-funded single-employer health benefit plan subject to ERISA, could not enforce the plan's subrogation provision because a Pennsylvania automobile insurance statute contains a general provision barring subrogation.<sup>3</sup> Thus, FMC was held barred from seeking any reimbursement of medical expenses which the plan paid pursuant to a participant's claim for benefits in connection with an injury resulting from an automobile accident,<sup>4</sup> although the claimant expressly agreed, as a condition for receiving the benefits, that he would reimburse the plan if he effected a recovery from any third party and did, in fact, recover.

<sup>3</sup> The Pennsylvania Motor Vehicle Financial Responsibility Law of 1984, 75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1984).

<sup>4</sup> The claim was made by respondent's father, an employee of FMC Corporation, on behalf of his minor daughter, a covered dependent, who was injured while a passenger in the affected car. (The facts are set forth in Petitioner's Brief.)

While acknowledging that the Pennsylvania statute "related to" an employee benefit plan, the Third Circuit ruled that it was "saved" from ERISA preemption as a state law regulating insurance. Although the FMC Plan was admittedly a self-funded plan rather than one providing benefits through the purchase of insurance, the court of appeals rejected the bright-line distinction between insured and self-funded plans set forth by this Court in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), and ruled that the "deemer" clause was inapplicable to the FMC plan because the Pennsylvania law did not conflict with a "core" ERISA concern.

The NCCMP submits that the decision below will have a significant adverse impact not only upon self-funded single-employer plans but upon its own affiliated plans as well as all of the nation's self-funded multiemployer plans, thereby undermining federal employee benefits law and policy as established and envisioned by Congress.

Multiemployer plans are created pursuant to collective bargaining agreements and are funded by contributions made by more than one employer, which are pooled for investment to pay benefits to all of the fund's participants and beneficiaries. Typically, even small multiemployer plans provide benefits to participants working or residing in more than one state; large national plans may have participants and beneficiaries in all 50 states.<sup>5</sup> These states all have automobile insurance laws of varying kinds whose provisions may, in many cases, differ

<sup>5</sup> By way of example, one of the relatively small welfare plans affiliated with NCCMP, the Southern Electrical Health Fund, although administered in Goodlettsville, Tennessee has processed benefit claims as well as subrogation claims on behalf of participants working or residing in at least five other states: Georgia, Alabama, South Carolina, Tennessee and New Jersey. A large affiliate, such as the nationwide Hotel Employees and Restaurant Employees Welfare Fund, which is centrally administered in Naperville, Illinois, has participants throughout the United States.

from the subrogation and coordination of benefits provisions of individual plans.

The NCCMP is concerned, first, that unless the Third Circuit's ruling is reversed, the trustees and administrators of multiemployer plans will be unable to establish and implement uniform administrative guidelines for the processing of claims and disbursement of benefits because plans having participants in different states—even if self-funded—will be subject to different regulatory requirements.

Second, it is well known that the cost of providing medical benefits has soared in recent years and shows no sign of abatement. At the same time, bargaining over health benefits has become a central issue in negotiating collective bargaining agreements and has been a major cause of strikes and other work stoppages throughout the country. As a result of economic pressures, self-funded multiemployer plans have been required to adopt a variety of cost-containment strategies while at the same time striving to maintain, to the extent possible, the benefits previously available to the plan's participants and beneficiaries and even to improve those benefits without imposing additional financial burdens.

Subrogation and coordination of benefits prevent plan participants from recovering double payments for the same illness or injury. As cost-containment strategies, they are particularly favored by multiemployer plans because they help conserve plan assets without restricting the benefits previously available and without imposing additional costs either on employers (through increased contribution rates) or on participants and beneficiaries (through increased deductibles and co-payment requirements).

The NCCMP is concerned that the Third Circuit's ruling, if not reversed, will make it impossible for multiemployer plans having participants in certain states to



utilize or to utilize fully subrogation and coordination of benefits as cost-containment strategies, thereby reducing the plan's ability to provide the desired health benefits at a cost contributing employers as well as plan participants and beneficiaries can reasonably afford, a result which may well have a substantial adverse impact on collective bargaining and could lead to a loss of participants (and contributions) not only for multiemployer welfare plans but for sister pension plans in affected industries as well.<sup>6</sup>

Third, ERISA gives trustees "exclusive authority and discretion to manage and control the assets of the plan." 29 U.S.C. § 1103. The statute, which has its roots in trust law, does not particularize the steps trustees must take to preserve, collect, increase, or disburse (in the form of benefits) the trust assets they control except to impose upon them certain fiduciary obligations. Hence, the details of trust administration must be set forth in a written trust agreement as well as in a written benefit plan which, together with the rules and regulations promulgated by the trustees to implement these plan documents, have critical importance in ERISA's administrative scheme. Typically, subrogation and coordination of benefits provisions are to be found in the benefit plan itself which, in turn, is explained to participants and beneficiaries in the "summary plan description" required by law. 29 U.S.C. §§ 1022, 1024(b).

Although ERISA imposes upon trustees a fiduciary duty to act in accordance with the plan's documents, so long as these documents are consistent with the objectives

<sup>6</sup> Typically, employers who contribute to multiemployer welfare plans pursuant to collective bargaining agreements also contribute to multiemployer pension plans. Higher contribution rates mean that a greater percent of the total wage package will be devoted to employee benefits or that the total cost of labor will increase. Either result increases the risk that employers will bargain out of multiemployer plans, thereby depleting the contribution pool necessary to pay benefits.

of the statute, 29 U.S.C. § 1104(a)(1)(D), the Third Circuit's ruling would bar trustees from uniformly enforcing a plan's subrogation and coordination of benefits provisions, even though such provisions are consistent with ERISA, in the event such provisions are found to be inconsistent with state law.

In its opinion, the Third Circuit enunciated a new and confusing test to determine whether a state insurance law should survive ERISA preemption. Under the new test, state law would be "saved" from preemption *unless* it conflicts with a "core" ERISA concern. In upholding the Pennsylvania insurance law in question, the court of appeals failed to appreciate that application of this state statute would undermine *core* ERISA concerns in *two* respects directly related to ERISA's fiduciary duty provision; the state law should therefore have been held preempted even under the court's own test. First, since the state statute would permit only selective enforcement of the FMC benefit plan, its application undermines a paramount federal interest in the uniform enforcement of plan documents except those that are inconsistent with *ERISA*; second, since the state statute would prevent enforcement, specifically, of the plan's subrogation provision, its application undermines the plan sponsor's cost-containment program which was designed to conserve and maximize plan assets so that the plan could continue to pay scheduled benefits in spite of escalating health care costs.

The NCCMP fears that the Third Circuit's new test will erode the "deemer" clause and "save" a whole variety of state statutes and common law rules regulating insurance, banking and securities, since courts are likely to differ on what they perceive as "core" ERISA concerns. The NCCMP is therefore concerned that the ruling, unless reversed, will not only increase the probability of litigation but will ultimately undermine the integrity and enforceability of plan documents generally.



Such a result will therefore undermine the ability of multiemployer plan trustees to recover monies owed to the trusts not only pursuant to such cost-containment programs as subrogation but in other areas of trust administration as well. Contrary to ERISA's goals, this result will ultimately undermine the ability of welfare and pension plans to maintain and pay the benefits promised to and relied upon by the plan's participants and beneficiaries.

The NCCMP's brief focuses on issues which it believes may not be adequately presented elsewhere, including:

(a) The particularly adverse impact that the holding below will have on the multitude of multiemployer plans represented by the NCCMP as well as upon national employee benefits policy; and

(b) The fundamental conflict between decisions of this Court, as well as those of other federal circuits, and the decision of the Court below.

#### SUMMARY OF ARGUMENTS

ERISA does not regulate the substantive details of trust administration or the substantive content of self-funded multiemployer welfare plans. However, the statute does impose certain fiduciary duties on the trustees of such plans: to act with prudence and reasonableness in the circumstances, to conserve plan assets, to pay benefits to participants and beneficiaries, and to comply with governing plan documents. By permitting a state insurance law to preclude enforcement of a plan provision that is consistent with ERISA, the Third Circuit's ruling has undermined the ability of multiemployer plan trustees, generally, to rely on the plan's governing documents to implement a uniform administrative system for the collection, disbursement, and conservation of trust assets.

By permitting a state insurance law to preclude enforcement of a plan's subrogation provision, the Third

Circuit's ruling has undermined the ability of multiemployer plan trustees to respond effectively to escalating health care costs, specifically, by designing and implementing uniform cost-containment strategies that are least burdensome to all of the plan's participants and beneficiaries as well as to employers funding the plan through collectively-bargained contributions. The trustees are therefore hampered in taking prudent, reasonable action that is likely to be least disruptive of labor peace and least likely to result in employers bargaining out of the plan, thereby reducing the contribution pool needed to pay scheduled benefits.

There can be no state interest in permitting plan participants to reap a double recovery for medical expenses paid while health care costs are threatening to destroy the private welfare system. However, by giving preference to a state's insurance scheme, the Third Circuit has undermined "core" ERISA concerns without even recognizing or correctly identifying their existence. The NCCMP therefore urges this Court to reaffirm the bright-line interpretation of the "deemer" clause set forth in *Metropolitan Life*, which has been followed by a majority of appellate courts, and thereby protect multiemployer benefit plans and their participants and beneficiaries from a patchwork of state insurance regulations, as Congress intended.

## ARGUMENTS

### **I. THE THIRD CIRCUIT'S DECISION WILL SUBSTANTIALLY LIMIT THE ABILITY OF MULTI-EMPLOYER PLAN TRUSTEES TO DESIGN AND IMPLEMENT COST-CONTAINMENT STRATEGIES IN RESPONSE TO ESCALATING HEALTH CARE COSTS, THEREBY UNDERMINING THE ABILITY OF MULTIEMPLOYER PLANS TO PAY THE BENEFITS PROMISED IN THE PLAN.**

#### **A. The Third Circuit's ruling will interfere with the efficient administration of multiemployer welfare plans because of the nature of such plans and the duties of their trustees.**

The Third Circuit's ruling places substantial restrictions on the ability of plan sponsors of all self-funded welfare plans to respond flexibly, as Congress intended, to the escalating costs of health care by designing and implementing cost-containment programs to conserve fund assets while continuing to pay the scheduled benefits promised in the plan. To help the Court evaluate the particularly adverse effect that the ruling is likely to have on the administration and financial soundness of multiemployer plans, the NCCMP presents a brief review of the nature of these plans, the duties of their trustees, and the centrality of plan documents to ERISA's administrative scheme.

Multiemployer employee welfare benefit plans are plans created by the parties to collective bargaining agreements for the purpose of providing health and welfare benefits to workers and their families.<sup>7</sup> These plans are self-funded primarily through the ongoing contributions of several, hundreds or even thousand of employers

<sup>7</sup> Many multiemployer plans also provide some type of coverage to retirees and their families. The cost of providing coverage to retirees places a particular burden on multiemployer plans, although such coverage is sorely needed.

in one or more industries involving participants working or living in several or many states.<sup>8</sup> The contributions are pooled for investment to provide benefits to all participants and beneficiaries of the plan.<sup>9</sup> Moreover,

<sup>8</sup> Employers contributing to plans affiliated with the NCCMP are primarily in the building and construction trades. However, a substantial number of employers are also in the food, hotel and restaurant, garment, and shipping industries. Representative plans cover asbestos workers, bakery, confectionery and tobacco workers, boilermakers, bricklayers, carpenters, cement masons, electrical workers, commercial and retail food workers, garment workers, glassworkers, glaziers, ironworkers, hotel and restaurant employees, laborers, millwrights, operating engineers, painters, plumbers and pipefitters, roofers, seafarers and other maritime employees, and textile workers. These plans have administrative headquarters in at least 37 states and cover participants and beneficiaries throughout the country. Large and small employers contribute to the plans pursuant to master labor agreements and individual collective bargaining agreements.

In October 1989, Robert A. Georgine, NCCMP Chairman, testified before the House Subcommittee on Labor Management Relations on the need for federal preemption of state laws as part of a national health policy. Mr. Georgine summarized the nature of multiemployer plans and their corresponding funding problem as follows:

To fully appreciate the Coordinating Committee's position, one must understand the nature of multiemployer plans. The primary source of multiemployer plan financing is current employer contributions. Since those contributions are based typically on work performed by covered workers (e.g., dollars-per-hour-worked), the plan's income fluctuates according to increases and decreases in covered work. Contribution rates are set normally for the term of an employer's collective bargaining agreement (often three to five years). Accordingly, multiemployer plans cannot increase their income quickly or easily. Unlike single employer plans, they do not have access to a corporate treasury.

The plan's board of trustees must balance the plan's benefit structure with expected income. This is often an exercise in allocating a "fixed economic pie" among the needs and wants of the workers and families covered by the plan.

a key feature of multiemployer plans is that participants can move from one contributing employer to another within the plan without losing their benefit rights, making such plans a model for portability.

While the parties to collective bargaining agreements negotiate the rate of contributions the employer will agree to pay during the life of the contract as well as the job classifications of employees to be covered by the agreement, the trustees of multiemployer plans generally have sole authority and exclusive power to determine the type and range of benefits the plan can and will provide and to establish eligibility requirements, given the plan's financial resources and such actuarial considerations as the number and age of participants and previous claims experience. Typically, the trust agreement governing the plan will establish the trustees' authority in this area,<sup>10</sup> and will empower them to establish benefit schedules and eligibility requirements, to establish a uniform scheme for processing and reviewing benefit claims, to construe the plan, to make binding resolutions of benefit disputes, and to amend the trust agreement and/or plan in response to perceived needs.

The plan of benefits itself, as distinct from the trust agreement, normally enumerates the plan's eligibility

<sup>10</sup> For example, Article Five, Section Six of the Trust Agreement governing the Hotel Employees and Restaurant Employees Welfare Fund empowers the Trustees "to adopt rules and regulations for the administration of the Welfare Fund and Welfare Plan and to promulgate the amount and nature of benefits payable to employees and dependents, the eligibility requirements for receiving benefits with respect to participation, length of service, and other conditions for obtaining welfare benefits, which the Trustees, in their sole discretion, may deem necessary and proper to effectuate the purposes of this Trust, and from time to time to alter, amend or change eligibility requirements as may be justifiable, to provide for portability of service for the payment of benefits, and to enter into reciprocity agreements with other welfare funds or plans; provided, however, that the exercise of such authority shall be on an actuarially sound basis."

requirements, the specific benefits provided, the specific benefits excluded, restrictions and limitations on benefits provided (including life-time ceilings and coordination of benefits), the participants' obligations (including deductibles, co-payment requirements, and subrogation), as well as information concerning the submission of claims and the right to appeal. In turn, the contents of the benefit plan must be summarized in a "summary plan description" which the plan must furnish to its participants in accordance with rules set forth in ERISA. 29 U.S.C. §§ 1022, 1024(b).

Given ERISA's roots in the traditional law of trusts, it is not surprising that plan documents play a central role in ERISA's structural design and administrative scheme. A significant and noteworthy feature of the statute is that Congress refrained from attempting to regulate either the substantive details of trust administration or the substantive content of welfare benefit plans. Having recognized that employee benefit funds differ from each other in so many respects, ERISA's drafters did not enumerate a comprehensive list of specific acts which the trustees were required to perform or of specific benefits the trustees were required to provide in order to fulfill their fiduciary obligation to conserve the trust assets committed to their care and control and to provide benefits to participants and beneficiaries.<sup>11</sup>

Rather, ERISA imposes a few affirmative duties on trustees and contains a few specific prohibitions, leaving the details of trust administration to be articulated in written plan documents, which are tailored to the needs and purposes of the particular plan or trust, and

<sup>11</sup> Correspondingly, this Court and other courts have recognized that self-funded employee benefit plans are not required to provide state-mandated health benefits. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Liberty Mutual Ins. Group v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384 (6th Cir. 1989).



which function as the blueprint for its governance. What Congress did mandate, however, is that trustees have a fiduciary obligation to act in accordance with the plan's governing documents, *i.e.*, to apply and enforce them to the extent these documents are consistent with ERISA. 29 U.S.C. § 1104(a)(1)(D).

Given the structure, design, and trust law roots of ERISA, a paramount federal interest clearly exists in protecting the integrity of plan documents by permitting plan sponsors *uniformly* to apply and enforce any provision, term, or rule that is consistent with that statute. Indeed, since trustees have a *fiduciary duty* to administer employee benefit plans in accordance with the plan documents, maintaining the integrity of these instruments is a "core" ERISA concern. The Third Circuit failed to examine the subrogation provision of FMC's plan in this light and, in barring its enforcement, took no account of the structural design of ERISA and the administrative realities of employee benefit plans.

**B. State law should not be permitted to interfere with core ERISA concerns by preventing plan sponsors from designing and implementing uniform cost-containment strategies in response to escalating health care costs.**

Since ERISA was enacted to promote the financial stability of employee benefit plans and to assure that their participants receive the benefits upon which they rely, *Nachman v. PBGC*, 446 U.S. 359 (1980), the Third Circuit's ruling, which limits the scope of ERISA's pre-emption provision by expanding the reach of the "savings" clause, must be assessed against the background of America's health care crisis. Reports are legion that the costs of providing health care have escalated out of all proportion and are threatening to destroy private welfare plans. Consequently, there can be no state interest in permitting a plan participant to obtain a double recovery for medical expenses paid by the plan. In per-

mitting a state insurance law to preclude enforcement of a plan's subrogation provision, the Third Circuit issued a ruling that conflicts with federal law and policy by failing to take into account the environment in which the plan operates and to which it must respond.

In 1987, according to data of the United States Health Care Financing Administration and Department of Commerce, national health expenditures represented a record 11.1% of the Gross National Product. 10 Employee Benefit Notes No. 2 at 3 (Feb. 1989). This figure is expected to reach nearly 12% in 1990 compared with 9.1% in 1980. *Trends in Medical Care Costs: A Look at the 1990s*, 71 Statistical Bull. No. 1 at 28 (Jan.-Mar., 1990).

One well-publicized study states that the cost of employer-provided medical plans skyrocketed 20.4% in 1989 and is expected to rise at a rapid pace.<sup>12</sup> Health spending could reach \$661 billion in 1990, reports the Commerce Department in its recently released 1990 U.S.

<sup>12</sup> 17 Pens. Rep. (BNA) 260 (Feb. 5, 1990), reporting on a survey conducted by A. Forster Higgins & Co., a benefit consultant. Surveys of health care costs abound. Although all agree that the cost of providing medical benefits has escalated in recent years, the results of the surveys vary depending upon the companies and plans surveyed. One study by a Connecticut-based firm, Corporate Health Strategies, which surveyed 21 employers having more than 200,000 employees below the age of 65, reported that the cost of providing health benefits soared 71% between 1983 and 1988. 23 Bus. Ins. No. 40 at 6 (Oct. 2, 1989). On the average, the increases appear to range from 10% to 25%. Increased costs are attributable, in varying degree, to the following factors: medical inflation (increase in hospital charges and physicians' fees); demand for and use of the latest and most sophisticated technology; increased claims for catastrophic problems such as AIDS, transplants, and neonatal care; shifting of costs by hospitals and doctors from the public to the private sector; increased utilization of inpatient and outpatient services; malpractice premiums and the use of "defensive" medicine. *Data Watch: What's Driving Health Care Costs?*, 7 Business and Health No. 1 at 6 (Jan. 1989).

*Industrial Outlook*. 20 Modern Healthcare No. 1 at 34 (Jan. 8, 1990). Correspondingly, the cost of health insurance is rising more than three times as fast as wages. 7 Benefits Today (BNA) No. 1 at 16 (Jan. 12, 1990). In 1988, according to data recently released by the Bureau of Labor Statistics, before-tax household income rose 4.4% while health insurance costs to consumers jumped 21%. Daily Lab. Rep. (BNA) No. 39 at B-1 (Feb. 27, 1990). This upward spiral is not abating.

According to a Department of Labor report, purporting to provide representative data for 31.1 million full-time employees in private nonagricultural industries, a growing trend is emerging toward self-funded plans. *Employee Benefits in Medium and Large Firms, 1988*, DOL Bur. of Lab. Stat. Bull. No. 2336 at 36 (Aug. 1989). However, self-funded plans have experienced increased health care costs ranging from 10% to 20% and project 1990 cost increases of up to 25%. 23 Bus. Ins. No. 52 at 18 (Dec. 25, 1989).

Collectively-bargained multiemployer plans are almost universally self-funded. In addition to the problems posed by inflationary health care costs, these plans are also affected by fluctuations in the economic climate. Thus, in periods of economic growth, contributions tend to increase because there are more "hours worked." At such times, workers also tend to postpone medical treatment. Conversely, in periods of economic downturn, contributions decrease while claims on the funds grow. Hence, many welfare funds are unable to keep pace with the rising cost of the medical benefits promised in their plans, particularly since such funds also tend to invest conservatively, with an eye toward safety and liquidity. Burroughs & Zurawell, *Health, Welfare Funds Suffer Sharply from Higher Health Costs*, 25 Pen. World No. 11 at 24 (Nov. 1989).<sup>13</sup>

<sup>13</sup> One NCCMP affiliate, an upstate New York based Carpenters Welfare Fund, reported that it is currently experiencing a contribu-

ERISA imposes on the trustees of multiemployer plans a fiduciary obligation to act "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." 29 U.S.C. § 1104(a)(1)(B).

Not surprisingly, the trustees of multiemployer welfare plans have been forced to consider and adopt a variety of cost-containment strategies to assure the continued viability of the plans. Among these strategies are: increased deductibles, ceilings on annual and or lifetime benefits; caps on claims for specific types of covered benefits (typically, treatment for alcohol and substance abuse, AIDS, and mental disorders); complete elimination of coverage for certain problems and procedures; reduced or eliminated coverage for dependents and retirees; and higher co-payment requirements. Alternatively, or additionally, employers have been required to contribute at higher rates in order for existing plan benefits to be maintained and for benefits to be improved.

However, unions and employers have both resisted one or more of these strategies, and bargaining over health coverage has led increasingly to labor disputes. For example, a 17-week strike at NYNEX Corporation, having 40,000 employees at the New York Telephone Company represented by the Communications Workers of America, centered on health insurance coverage. A similar strike by the Company's 20,000 employees repre-

tion decline due to a recessionary climate in the home building industry. At the same time, the Fund, which provides benefits to about 600 active employees and 100 retirees and their dependents, has received increased claims for substance abuse and alcohol-related problems. In response, the plan has recently imposed a co-payment requirement (80/20) and placed a cap on claims for clinical and psychological treatment.

sented by the International Brotherhood of Electrical Workers at the New England Telephone Company was over the same issue. Both unions were ultimately successful in preserving benefits with no employee co-payments. 16 *Pens. Rep.* (BNA) 2094 (Dec. 11, 1989). A 10-month strike by the United Mine Workers against the Pittston Coal Group also centered on health coverage as did strikes in other industries from retail food to auto parts. 16 *Pens. Rep.* (BNA) 2025 (Nov. 27, 1989).

A three-year study prepared by the Service Employees International Union, *Labor and Management: On a Collision Course over Health Care*, while recommending a "systemic change" in the way health care is provided, states that the number of strikes over who will pay the rising costs of health care has increased by more than 300% since 1986, and that such work stoppages in 1989 alone cost the United States economy more than \$1.1 billion dollars in lost wages and productivity. 17 *Pens. Rep.* (BNA) 375 (Feb. 26, 1990).

Two cost-containment strategies that do not increase the financial burden either on employers or on employees and do not require the reduction or elimination of benefits are coordination of benefits and subrogation. These strategies are therefore favored by the trustees of multi-employer plans.<sup>14</sup>

<sup>14</sup> The NCCMP will limit its discussion to subrogation since the Third Circuit's decision involved only the antishubrogation provision of the Pennsylvania automobile insurance statute. However, the court of appeals, in enunciating its new test to determine whether a state law should survive ERISA preemption, relied heavily on a 1987 Sixth Circuit decision which, for similar reasons, "saved" the coordination of benefits provision of Michigan's no-fault statute from preemption and therefore barred enforcement of a conflicting coordination of benefits provision in a self-insured plan subject to ERISA. *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987). Coordination of benefits are rules that prevent duplicate recovery where a participant is covered by more than one plan or policy. Cost containment is achieved by a plan by

Like coordination of benefits, subrogation prevents a participant from obtaining a double recovery. Cost containment is achieved by requiring the participant to reimburse the plan for expenses paid in connection with an injury arising from an accident if and to the extent the participant recovers these expenses from a third party. Most subrogation claims arise in connection with automobile accidents. However, plans can seek reimbursement from the participant's recovery in other liability insurance contexts as well, for example, home owners, malpractice, dram shop, or worker's compensation.<sup>15</sup>

Multiemployer plan subrogation programs typically operate as follows. If the claim form submitted by the participant indicates facts suggesting that a third party may be liable for the expenses, the participant (and, if

deeming itself "secondary" and the "other insurance" primary. Under Michigan's no-fault statute, however, health insurance is considered primary and no-fault automobile insurance secondary if the no-fault insurer offers and the insured elects to coordinate benefits with his or her health insurance.

In *Northern Group Services*, the Sixth Circuit ruled that the no-fault insurance would be considered secondary regardless of the language of the health insurance plan, stating that there was no ERISA interest in uniformity that outweighed the McCarran-Ferguson Act interest in state regulation of insurance. As applied to multiemployer plans, the Sixth Circuit's decision is no less inimical to ERISA's core concerns than the Third Circuit's ruling at bar, since the effect of the two decisions is to preclude multi-employer plans from fully utilizing the *only* cost-containment strategies that do not limit benefits or impose additional costs on participants and beneficiaries or employers.

<sup>15</sup> Most plans expressly exclude coverage for work-related injuries. However, whether an injury is work-related is often in dispute. Typically, the plan will pay the participant's medical expenses on condition that the plan will be reimbursed if the participant recovers from the worker's compensation carrier. The advantage to the participant in this and similar situations is that his or her medical expenses will be paid when needed and disputes will be resolved at a later time.



appropriate, the dependent) is required to sign an agreement promising to reimburse the plan in the event of a recovery as a condition to receiving the benefits claimed. The participant is not required to file suit against a third party, but may not do anything to prejudice the plan's recovery. At a minimum, the participant is therefore required to notify the plan whether or not he or she intends to file a claim with an insurance company or to file suit against a tortfeasor and, if so, to provide the plan with relevant information. The plan may take such action itself, although it is not required to do so. Usually, the plan, through counsel, simply files subrogation liens with all relevant insurance companies and attorneys, thereby notifying them of its subrogation interest. Though a plan may sometimes intervene in a participant's action to protect its lien, such action is frequently unnecessary. The majority of personal injury claims are settled out of court and insurance companies and attorneys tend to honor subrogation liens filed by multiemployer plans.

Although statistics are not yet available to "prove" the effectiveness of subrogation programs,<sup>16</sup> it is clear that such programs constitute a cost-effective, efficient way for plans to respond to escalating health care costs.<sup>17</sup>

<sup>16</sup> One 1984 study suggests that a vigorous subrogation program can result in the recoupment of 1% to 2% of all medical claims paid and can be much more. Wille, *Subrogation Third Party Reimbursement: An Overlooked Way to Reduce Health Benefit Costs*, 1 Health Cost Management No. 9 at 3 (June 1984).

<sup>17</sup> The NCCMP cannot offer the Court statistics on the success rate of its affiliates' subrogation programs, in part, because this method of cost-containment is relatively recent. However, by way of example, the Southern Electrical Health Fund has recently initiated a vigorous subrogation program. In the past six months, a total of 63 files were opened, involving claims totalling \$513,596.01. Twenty-one cases have since been closed, of which seven were deemed uncollectible for procedural reasons. The fourteen remaining cases yielded payments of \$63,064.24. The plan expects to collect a further \$149,570.57 on twelve additional claims. Ten pending claims, in-

However, if the Third Circuit's ruling is not reversed, these programs (and other cost-containment measures such as coordination of benefits) will be seriously hampered because a key feature of multiemployer plans is that their participants reside or work in different states and may also move from state to state in covered employment without losing their eligibility for benefits. Given the variety of state laws regulating automobile and other types of liability insurance, including worker's compensation, multiemployer plans will be faced not only with administrative uncertainty and increased administrative costs as a result of differing state schemes but also with a potentially significant loss of revenue since some of these state laws bar subrogation (and or coordination of benefits) and a participant could select one of these fora specifically to prevent the plan's recovery. *Howard v. Alfrey*, 697 F.2d 1006 (11th Cir. 1983). Such results are not tangential to "core" ERISA concerns, as the Third Circuit erroneously believed; they are contrary to and undermine the basic purposes and principles of the statute.

In sum, there can be no state interest in permitting plan participants to obtain a double recovery for medical expenses while the nation's health care system is in crisis and escalating costs are threatening to destroy private welfare plans. Given the Third Circuit's illustrative failure to recognize a "core" ERISA concern, the NCCMP urges this Court to reject the test enunciated by the court of appeals, to reaffirm the bright-line distinction it articulated in *Metropolitan Life*, and to reverse the holding below.

v. involving \$115,273.33, do not appear favorable. However, if SEHIF succeeds in collecting \$212,634.81, as expected, the plan will have recovered 41.40% of its current subrogation claims solely by filing liens and without litigation. In an average month, the plan extends coverage to about 2,557 eligible participants. In 1989, it paid \$6,821,861.45 in claims (an increase of 16.5% over 1988). In 1989, employer contributions totalled \$7,015,539.94 (a 2.9% increase over 1988). Thus, the plan's expected recovery on its 63 initial subrogation claims is roughly 3.10% of total claims paid in 1989.

**II. SECTION 514(b)(2)(B) OF ERISA WAS INTENDED TO PREEMPT ALL STATE INSURANCE REGULATION AFFECTING SELF-FUNDED EMPLOYEE BENEFIT PLANS AND THE THIRD CIRCUIT'S RULING IS INCONSISTENT WITH DECISIONS OF THIS COURT AND THE WEIGHT OF APPELLATE AUTHORITY.**

The NCCMP supports the arguments set forth in Petitioner's brief and will limit its discussion here to those aspects of the Third Circuit's ruling that are particularly adverse to the efficient, cost-effective administration of multiemployer plans and their financial soundness.

**A. The Third Circuit's ruling abandons the bright-line test for preemption that is necessary for the uniform administration of multiemployer plans.**

In *Metropolitan Life Ins. Co. v. Massachusetts*, *supra*, this Court, after examining the language of ERISA, its legislative history, and its own previous decisions, concluded that Congress was fully aware that two distinct types of benefit plans were covered by ERISA (insured and self-funded), and that Congress intended to exempt self-funded plans from the direct effects of all state insurance regulation.

The Courts of Appeals for the Fourth, Fifth, Seventh, Eighth and Ninth Circuits have followed the bright-line distinction set forth in *Metropolitan Life* in a variety of factual contexts,<sup>18</sup> implicitly or explicitly recognizing the adverse consequences of an alternative approach for the administration and financial soundness of self-funded plans.

<sup>18</sup> *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986); *Children's Hosp. v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985); *Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F.2d 416 (7th Cir. 1988), *cert. denied*, 109 S. Ct. 145 (1988); *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986).

In contrast, the Third and Sixth Circuits,<sup>19</sup> reasoning that this Court's distinction between insured and self-funded plans is dictum, departed from *Metropolitan Life* and established new tests by which to determine whether a state insurance law or regulation is "saved" from the reach of the "deemer" clause and therefore from federal preemption.

In the Third Circuit's view, the proper inquiry is not whether a plan is insured or self-funded, but whether the "state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the preemption provision." 885 F.2d at 90. However, while eschewing the *Metropolitan Life* distinction, as well as its "categorical" application by the Ninth Circuit in *Pacyga*, *supra*, the court of appeals nevertheless states (as does the Sixth Circuit) that the distinction does not "disappear." Rather, insured plans *per se* survive the "deemer" clause, which would therefore permit application of state insurance law, while self-funded plans would be considered on a "case by case" basis to determine whether the state law "conflicts with a substitute mandate in ERISA." *Id.*

Opining that the "deemer" clause was primarily intended to protect ERISA plans from "intentional" or "pre-textual" attempts by states to regulate them in the guise of insurance, the Sixth Circuit ruled in *Northern Group Services*, *supra*, that "for the deemer clause to override the savings clause in a given case, there must be some ERISA interest in uniformity to outweigh the McCarran-Ferguson interest in state regulation of insurance." 833 F.2d at 95.

The tests suggested by both courts are confusing and likely to lead to administrative uncertainty for multiem-

<sup>19</sup> *FMC Corporation v. Holliday*, 885 F.2d 79 (3d Cir. 1989); *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987).

employer plans as well as to an increased potential for litigation and conflicting results.

If state insurance regulation is not *per se* preempted as applied to self-funded multiemployer plans, the first difficulty facing a plan administrator is the question of which state law will govern in the event of a perceived or claimed conflict with the plan document. As noted earlier, multiemployer plans administered in one state tend to cover participants who live and/or work in different states or who move from one state to another in covered employment. Typically, the trust agreement governing the plan will provide that the law of the state in which the trust is administered will govern the operation of the trust except as preempted by ERISA. If ERISA does not, as a matter of federal law, mandate enforcement of all plan documents and a participant is involved in an accident in another state, the plan administrator will have to determine, first, which state's law is likely to apply so as to determine how benefits should be coordinated or whether a subrogation claim should be made. Since complex conflict of laws issues may arise, subrogation and coordination of benefits will no longer be routine matters, and it may become necessary for the plan to involve counsel increasingly in the processing of claims. Thus, subrogation and coordination of benefits will lose some of their effectiveness as cost-containment mechanisms. Moreover, either federal courts will have to develop a body of federal conflicts law to resolve disputes between state laws and plan documents or the enforcement of plan documents will be subject not only to state insurance laws but also to state conflicts rules in derogation of a paramount federal interest in the uniform federal regulation of employee benefit plans.

Even if there is no difficulty in determining which state's law should apply, federal courts, when asked to resolve a conflict between enforcement of a plan document and state law, will be required, in each "given case," to

undertake an exhaustive review of the state law in question (including its legislative history and cases construing it) in order to determine such questions as: whether the state scheme seeks to regulate insurance or to regulate a plan in the guise of insurance; whether its effect on a plan is intentional or unintentional; if unintentional, whether its effect conflicts with a "substitute ERISA mandate;" and, if so, whether the substitute mandate is a "core type of ERISA matter" or one requiring "uniformity." As the Third and Sixth Circuits' opinions indicate, different and conflicting answers to such questions will be inevitable and may result in substantive holdings that are inimical to central tenets of ERISA. This has already occurred in the ruling below as well as in *Northern Group Services, supra*.

In *Holliday*, the Third Circuit barred enforcement of a plan's subrogation provision and permitted a participant to enjoy a double recovery to the detriment of the plan because it failed to recognize as a "core type of ERISA matter" that plan sponsors have a fiduciary obligation to design and implement all measures that are reasonable and necessary in the circumstances to conserve plan assets so that the plan can pay the benefits promised to its participants and beneficiaries. Significantly, the court of appeals upheld the state statute's antisubrogation provision merely because it was there. Not the slightest attempt was made to show how the antisubrogation provision of the Pennsylvania law was even arguably related to a state interest worthy of protection under the McCarran-Ferguson Act, the federal statute that underlies ERISA's "savings" clause and returns to the states the business of regulating insurance companies and insurance contracts. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982). Consequently, in its first departure from *Metropolitan Life*, and its first attempt to apply its own test to a self-funded plan on a "case by case" basis, the court made a ruling that, in barring subrogation, will certainly affect the FMC



plan adversely and threatens the financial soundness of every self-funded plan in the nation as well.

In *Northern Group Services*, the Sixth Circuit achieved an equally ominous result by striking down a plan's coordination of benefits rule on the grounds that the plan's provision conflicted with Michigan's no-fault insurance law. In contrast to the Third Circuit, the Sixth Circuit devoted much of its opinion to justifying Michigan's interest in assuring that the coordination of benefits provisions of no-fault policies are uniformly interpreted to place primary liability on the insured's health policy or plan instead of on his or her automobile insurance carrier. Turning proper preemption analysis on its head, the court indicated that the state insurance law should not be preempted, even as applied to a self-funded plan, because preemption would frustrate the state's goals of cost containment, predictability, and the financial stability of no-fault insurers. 833 F.2d at 93. The court could find no countervailing federal interest in uniformity to outweigh the state's interest in preserving its own insurance scheme, although the goals set forth in support of "saving" the state law are *precisely* those which, as applied to a self-funded plan, would require federal preemption because they promote "core types of ERISA matters."

Significantly, another panel of the Sixth Circuit departed from *Northern Services* and declined to interpret Michigan's no-fault insurance statute to require a plan to provide coverage for injuries arising out of automobile accidents. The court ruled that even if the Michigan statute required this result, it would be preempted in the same way that mandated-benefits statutes are preempted as applied to self-funded plans. *Liberty Mutual Ins. Group v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384 (6th Cir. 1989).

In contrast to these decisions, the majority of courts of appeals have followed the bright-line test set forth

in *Metropolitan Life*, and have exempted from the reach of the "savings" clause all self-funded employee benefit plans. In so doing, these courts have recognized that this Court has rejected as unworkable the conflict-oriented analysis of the "deemer" clause espoused by the Third and Sixth Circuits, and has already provided common-sense guidelines to assure that self-funded employee benefit plans will be uniformly protected against the incursion of state insurance regulations. A bright-line test is necessary for the efficient, cost-effective administration of self-funded employee benefit plans, especially multiemployer plans. The NCCMP therefore urges this Court to reject the analyses of the Third and Sixth Circuits and to reaffirm its interpretation of the "deemer" clause as set forth in *Metropolitan Life*.

**B. This Court's distinction between insured and self-funded plans is consistent with the text and legislative history of ERISA and should be reaffirmed in the case at bar.**

Departing from *Metropolitan Life*, the Third Circuit objected that this Court read into the statute a distinction that was not there, thus permitting the "deemer" clause to "swallow" the "savings" clause. This contention is clearly error, particularly as applied to collectively-bargained self-funded multiemployer benefit plans that are maintained and established as trusts within the meaning of Section 302(c)(5) of the Labor-Management Relations Act, 1947, as amended, 29 U.S.C. § 186(c)(5), and Sections 402 and 403 of ERISA, 29 U.S.C. §§ 1102 and 1103.

Section 3(1) of ERISA defines an "employee welfare benefit plan" as any "plan, fund, or program" that provides health or medical benefits "either through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). Section 4(a) provides that Title I of the statute, except as expressly excluded, covers any "employee benefit plan" that is established or maintained by an employer, a union,

or both. 29 U.S.C. § 1003(a). Finally, Section 514(b)(2)(B) of ERISA provides that “neither any employee benefit plan described in section 1003(a) . . . nor any trust established under such a plan” shall be “deemed” to be an insurance company, an insurer, or to be engaged in the business of insurance for the purpose of state laws regulating insurance and saved from federal preemption by Section 514(b)(2)(A). 29 U.S.C. § 1144.

Applying the plain meaning rule for construing statutes as well as common sense, this Court recognized that ERISA, on its face, clearly covers two distinct types of benefit plans, those which provide benefits through the purchase of insurance from commercial insurance companies that are themselves subject to state regulatory schemes, and those which provide benefits from corporate assets or employer contributions and which Congress intended to exempt from state regulation. The text of ERISA fully supports the Court’s distinction in *Metropolitan Life*, particularly as applied to collectively-bargained multiemployer trust funds whose corpus consists of employer contributions. Contrary to the Third Circuit’s view, the distinction between insured and self-funded plans does not “swallow” the “savings” clause but permits states now as before to regulate commercial insurance companies and their contracts (though not the plans themselves) while leaving the plan sponsors of self-funded plans free to make benefit decisions that are sensitively tailored to the needs of their specific plans in accordance with ERISA’s fiduciary duty rules.

When asked to review whether a particular state law is preempted by ERISA, this Court has repeatedly stated that “as in any pre-emption analysis, ‘the purpose of Congress is the ultimate touchstone.’” *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 8 (1989). ERISA’s sponsors have stated this purpose with great clarity. Thus, Representative Dent asserted that “with the preemption of the field [of employee benefits], we round out the protection

afforded participants by eliminating the threat of conflicting and inconsistent local regulations.” 120 Cong. Rec. 29197 (1974). Senator Williams made similar statements. *Id.*, at 29933. In this Court’s view, “these statements reflect recognition of the administrative realities of employee benefit plans.” *Id.* at 9.

Speaking of self-funded single-employer plans, the Court observed that “[a]n employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others. . . .” *Fort Halifax Packing Co. v. Coyne*, 482 U.S. at 9.

Given these difficulties, this Court indicated that it was prepared to enforce ERISA’s preemption provision whenever necessary to prevent the subordination of a plan’s administrative scheme to conflicting state insurance regulation. The difficulties besetting self-funded single-employer plans are magnified in the case of self-funded multiemployer plans. As the Court recognized in *Fort Halifax*, however, federal preemption assures that the administrative practices of employee benefit plans will be governed by a single set of regulations, as Congress intended, rather than by a patchwork scheme of conflicting state law. *Id.*, at 11. The Third Circuit’s rul-

ing is inconsistent with these principles and should be reversed.

### CONCLUSION

ERISA provides and Congress intended that self-funded welfare benefit plans be exempt from the reach of state insurance regulation, in recognition of the administrative realities of such plans and the need for uniformity. The Third Circuit, misperceiving the text and the legislative history of the statute, has created a new and disruptive test to determine whether a state insurance law should survive federal preemption. In so doing, the court has placed serious limits on the ability of multiemployer welfare plan trustees to rely on a plan's governing documents to implement a uniform system of trust administration and to respond effectively to the escalating costs of health care. The court of appeals' failure to identify "core" ERISA concerns illustrates that its conflict-oriented "case by case" interpretation of the "deemer" clause is unworkable and inconsistent with the central purposes and policies of ERISA. For all of the reasons stated above, the NCCMP respectfully urges this Court to reverse the decision of the Third Circuit and to reaffirm the bright-line test for preemption set forth in *Metropolitan Life*.

Respectfully submitted.

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*In the Supreme Court of the United States*

OCTOBER TERM, 1989

FMC CORPORATION, PETITIONER

*v.*

CYNTHIA ANN HOLLIDAY, RESPONDENT

*ON WRIT OF CERTIORARI TO THE  
UNITED STATES COURT OF APPEALS  
FOR THE THIRD CIRCUIT*

**BRIEF AMICUS CURIAE OF  
AMERICAN OPTOMETRIC ASSOCIATION  
IN SUPPORT OF RESPONDENT**

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ON WRIT OF CERTIORARI TO THE  
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**BRIEF AMICUS CURIAE OF  
AMERICAN OPTOMETRIC ASSOCIATION  
IN SUPPORT OF RESPONDENT**

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The American Optometric Association submits this brief amicus curiae in support of respondent. Letters granting consent, received from counsel for each of the parties, have been filed with the Clerk of this Court.

**INTEREST OF AMERICAN OPTOMETRIC ASSOCIATION**

The American Optometric Association ("AOA"), a non-profit membership organization incorporated under Ohio law, is a national professional association of more than 27,000 members consisting of licensed Doctors of Optometry, optometry students, and educators. AOA's objects, as set forth in its Constitution, "are to improve the vision care and health of the public and to promote the art and science of the profession of optometry." AOA has as affiliates the State optometric associations in each of the



50 States and in the District of Columbia, the Armed Forces Optometric Society and the American Optometric Student Association.

As the national professional organization representing the optometric profession, AOA has always been, and is now, vitally interested in matters which affect the adequacy of vision care available to the public. This includes, among other things, AOA's interest in supporting and sustaining what is usually called "freedom of choice" legislation, whether in connection with insured or self-funded health care plans. "Freedom of choice" is the universally enacted State legislation which, so far as it applies to the field of vision care, prevents insurance companies, health benefit plans and others from discriminating against the practice of optometry; it likewise prevents discrimination against patients who in obtaining vision care wish to utilize the professional services of optometrists instead of physicians for those services within the lawful scope of the practice of optometry.

The present case is one of a series that—depending on what this Court says about the scope of the ERISA preemption—may have a substantial impact on such matters on a national basis. When the Massachusetts ERISA litigation was before this Court, AOA filed a brief amicus curiae in support of the Commonwealth of Massachusetts, urging affirmance. The Massachusetts court had held that the "mandated benefit" provision (requiring reimbursement to be made for certain mental illness costs), which the Massachusetts statute made applicable to employee health benefit plans placed with insurance carriers, was not preempted by ERISA because such application of the mandated benefit statute was saved by the insurance savings clause in ERISA's preemption provision. This Court affirmed the judgment. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985). AOA also urged that, no matter what decision this Court

might reach as to whether the Massachusetts mandated benefit statute was preempted, the Court should in any event avoid any intimation which might impair or cast a cloud on the continuing validity of the widely-adopted, but very different, State freedom of choice legislation. We submit that the Court's opinion in *Metropolitan Life* was responsive likewise to this concern.

The substance of AOA's position is this: While the broad preemption language in ERISA is to be interpreted generously, the preemption should not be given an overzealous overbreadth which would smother legitimate State legislation that Congress never would have intended to displace. In the present case the Third Circuit's judgment strikes a fair balance between the conflicting contentions of the parties concerning the antissubrogation provision of the Pennsylvania Motor Vehicle Financial Responsibility Law. By legislation generally applicable to actions arising out of the maintenance or use of a motor vehicle, Pennsylvania has provided that there shall be no right of subrogation with reference to a broad range of recoveries. The question here is whether ERISA's preemption provisions nullify this Pennsylvania statute with respect to certain medical expenses paid out by petitioner's health benefit plan for automobile accident injuries suffered by respondent. If such preemption occurs, then petitioner will recoup the money and respondent will be deprived of the antissubrogation protection which the Pennsylvania legislature has sought to confer generally on persons who are injured in automobile accidents. While AOA's interest in the narrower aspects of the issue as to this antissubrogation provision may seem in some respects peripheral, AOA's interest in this Court's disposition of the case is strong.

### SUMMARY OF ARGUMENT

As the Third Circuit correctly viewed the case, the question of the valid applicability of the antissubrogation provision in the Pennsylvania Motor Vehicle Financial Responsibility Law called for the examination, if necessary, of three successive clauses in the preemption provisions in Section 514 of ERISA, 29 U.S.C. §1144—namely, the “preemption clause,” the “insurance savings clause,” and the “deemer clause.”

The “preemption clause” itself starts off by preempting “all State laws insofar as they may now or hereafter relate to any employee benefit plan.” Here the critical word is the word “relate.” While it is broad, it is not to be given an unlimited or overbroad reading. The teachings of prior decisions, and particularly *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988), show that some reasonable limits must be placed on it, and that general State legislation which happens to have some impact on ERISA plans does not necessarily come within this preemption clause. The antissubrogation provision of the Pennsylvania Motor Vehicle Financial Responsibility Law is illustrative of the type of general State legislation which should not be caught by the net of the ERISA preemption clause’s “relates.” The Third Circuit too readily came to the contrary conclusion; its judgment should nevertheless be affirmed on the ground that the preemption clause does not apply as an initial matter. But in any event, and however this Court may now decide to treat this question, AOA urges that care be taken to avoid any intimation which might impair or cast an ERISA cloud on the validity of any of the widely-enacted State freedom of choice legislation.

However, if it be either decided or assumed for purposes of decision that the ERISA preemption clause does initially apply to the antissubrogation provision in the

Pennsylvania Motor Vehicle Financial Responsibility Law, then the next question is whether the antissubrogation provision is a law which “regulates insurance” within the meaning of ERISA’s insurance savings clause. On this question there has been no controversy; the parties and amicus all agreed below that the antissubrogation provision is in fact a law which “regulates insurance” within the meaning of the savings clause. The Third Circuit correctly concluded that this is plainly so, and the conclusion is beyond reasonable challenge.

This brought the Third Circuit to a detailed analysis of the deemer clause. Its conclusion that certain limits must be placed on the deemer clause is supported by not only the structure of ERISA but by the extensive legislative history recounted in the Third Circuit’s opinion. This led the Third Circuit to the view that self-insured plans must be considered under the deemer clause on a case-by-case basis to see whether the State regulation concerned “affects a central concern of ERISA” (885 F.2d at 89; Pet. A27). For the persuasive reasons specified by the Third Circuit—even if the Pennsylvania antissubrogation provision were held or assumed to be covered initially by the preemption clause—the deemer clause does not apply. Hence the Pennsylvania antissubrogation provision is not removed from the insurance savings clause and is not wiped out by ERISA preemption.

### ARGUMENT

In seeking to find an accommodation of ERISA’s rather complex, and by no means crystal-clear, preemption provisions, this Court and the lower federal courts sensibly have proceeded on a case-by-case basis. AOA’s primary interest in this and comparable litigation is to assure that, when the issue finally comes squarely before this Court (if it ever does), all of the State freedom of choice laws

are sustained against any claim of ERISA preemption.<sup>1</sup> As ERISA preemption law develops in the meantime, no needless impediment should be placed in the way of this ultimately sound result.

At the outset it should be noted that the freedom of choice laws are totally unlike the mandated-benefit law which was before this Court in the Massachusetts litigation. The State freedom of choice laws do not require that a health plan shall cover any particular illness or condition. They do not force upon a plan the coverage for this or that illness or condition. For example, with respect to vision care, the freedom of choice laws do not require that a plan cover vision care at all; and if the persons responsible for formulating the plan do wish to cover particular aspects of vision care, the freedom of choice laws do not dictate which types of eye diseases or eye conditions or eye examinations shall be covered or with what frequency such coverage may be availed of by the employee.

Instead, the freedom of choice laws consist of a vast body of State enactments, on the books in one or more forms in all 50 of the States and in the District of Columbia, which safeguard a patient's freedom of choice to select a provider of a particular health care service. With

<sup>1</sup> When *Blue Cross Hospital Service, Inc. v. Frappier* was remanded by this Court, 472 U.S. 1014 (1985), for further consideration in light of *Metropolitan Life*, supra, the Missouri Supreme Court disposed of the case by holding that, in the light of *Metropolitan Life*, it is clear that State freedom of choice statutes applicable to insured plans (such as the Missouri statute) come within ERISA's insurance savings clause and hence are not preempted by ERISA. *Blue Cross Hospital Service, Inc. v. Frappier*, 698 S.W. 2d 326 (Mo. 1985). Accord, *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986), holding that the Kansas freedom of choice statute applicable to insured plans comes within ERISA's insurance savings clause and hence has not been preempted by ERISA.

respect to vision care coverage—if and to the extent that such coverage is actually provided for by an employee benefit plan—this means that there was and is pervasive State legislation requiring that the plan reimburse the patient who prefers to use the professional services of an optometrist (instead of a physician), as long as the services come within what may lawfully be performed by a licensed optometrist under the laws of the particular State. Moreover, the freedom of choice laws do not inflict on the benefit plans any additional costs in the vision care field; and indeed, practical experience has indicated that, on the whole, the costs of services performed by optometrists tend to be less than the costs of comparable services performed by ophthalmologists.

Throughout the Nation these freedom of choice statutory provisions have been enacted to assure to the patient his or her right of choice and, so far as vision care is concerned, to prevent discrimination against using the professional services of optometrists. The freedom of choice statutes represent deep-rooted policies of the States concerned, in a field normally governed by State law. Moreover, since optometrists usually are more widely dispersed geographically, and more conveniently located, within a State than are ophthalmologists, such legislation helps to assure that patients, particularly the elderly, will have greater access to convenient prepaid health care.<sup>2</sup>

<sup>2</sup> In 1980, Congress expanded Medicare coverage to include services performed by optometrists in connection with the condition of aphakia. See 42 U.S.C. §1395x(r)(4), discussed in note 4 infra. In a 1976 Report recommending the adoption of this amendment, the Department of Health, Education and Welfare stated: "6. Access to services. Vision/eye care services for aphakic and cataract patients, as well as for patients more generally, can be made more accessible to the Medicare eligible population by providing reimbursement for services when provided by optometrists. In general, optometrists



Accordingly, it has been and remains AOA's position that:

(1) State freedom of choice laws are outside the scope of ERISA's "preemption clause" fairly interpreted—this turns on a fair but not over-extravagant reading of the phrase "all State laws insofar as they may now or hereafter relate to any employee benefit plan," in Section 514(a) of ERISA, 29 U.S.C. §1144(a); and

(2) in any event, proper recognition should be given to the scope of the "insurance savings clause" in Section 514(b) of ERISA, 29 U.S.C. §1144(b)—it is clear that insured benefit plans are plainly covered by the insurance savings clause under the doctrine of *Metropolitan Life*, supra; at least some of the freedom of choice laws are readily classifiable as a law "which regulates insurance" whether the particular benefit plan is insured or self-insured or a combination of the two; and

(3) in any event, the "deemer clause," Section 514(b)(2)(B) of ERISA, 29 U.S.C. §1144(b)(2)(B), should be properly interpreted, so as to confine its reach to its true purpose and scope—as the Third Circuit has done in this case.

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are more widely distributed geographically and practice in many smaller communities where other vision/eye care practitioners are not available." U.S. Department of Health, Education and Welfare, *Report to Congress: Reimbursement Under Part B of Medicare For Certain Services Provided by Optometrists*, as required by Title I, Section 109, of P.L. 94-182 (July 1976), p. v. Similarly, in connection with a 1986 Medicare amendment eliminating discrimination against optometry (also discussed in note 4 infra) the House Committee Report stated: "Many beneficiaries are either foregoing covered eye care or are paying out-of-pocket for eye care services furnished by optometrists because they do not have ready access to an ophthalmologist and because the present rules are too difficult to understand." H.Rept. 99-727, 99th Cong., 2d Sess., p. 81 (October 17, 1986).

No one can reasonably quarrel with the Third Circuit's observation in this case that "ERISA's section 514, 29 U.S.C. §1144, is hardly a model of legislative draftsmanship." 885 F.2d at 83; Pet. A11. But by now the starting point is this Court's analysis in *Metropolitan Life*, supra, to the effect that the Massachusetts mandated benefit law "relates to" ERISA plans, "and thus is covered by ERISA's broad pre-emption provision," 471 U.S. at 739—though, as it turned out, for the insured plans in issue there, the Massachusetts law was saved by the insurance savings clause.

The contention that the Pennsylvania antisubrogation provision does not "relate," in the ERISA sense, is a contention which was decided by the Third Circuit adversely to respondent (885 F.2d at 85; Pet. A15). Nevertheless, respondent here may rely on this contention as an independent ground in support of the judgment below. See, for example, *United States v. Arthur Young & Co.*, 465 U.S. 805, 814 note 12 (1984); *Blum v. Bacon*, 457 U.S. 132, 137 note 5 (1982); *Granfinanciera, S.A. v. Nordberg*, 109 S.Ct. 2782, 2788 (1989).

About two years before *Metropolitan Life* was decided, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), had acknowledged that some State laws "may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan," 463 U.S. at 100 note 21, and cited as an example a decision holding that State garnishment of a spouse's pension income to enforce alimony and support orders is not preempted. Nothing in *Shaw* addressed the question whether freedom of choice laws came within the pre-emption clause; and the *Metropolitan Life* opinion was meticulous in leaving this matter for future consideration.

Freedom of choice laws raise the question of what is

the fair and reasonable interpretation of the word "relate" in ERISA's preemption clause. In our highly interdependent world, it can be argued that almost anything "relates" to almost anything else, and yet it must be clear that Congress could not have intended that the doctrine of preemption be carried to the utmost or even too far.

For example, it might be argued that a State law which imposes minimum safety standards for x-ray equipment used in a clinic examining and treating employees under a plan is a law which "relates" to an employee benefit plan; yet it is hard to believe that anyone would take seriously the claim that ERISA preempts such a State law. For another example, a State law which imposes certain minimum fire safety standards on a facility made available to employees under a benefit plan could, arguably, be said to be a law which "relates" to the plan; but, again, the contention that ERISA preempts such a law would defy common sense.

In other words, an appropriate place must be found for deciding where, under ERISA, the preemption line is to be drawn. As the Second Circuit stated in *Rebaldo v. Cuomo*, 749 F.2d 133, 138 (2nd Cir. 1984), certiorari denied, 472 U.S. 1008 (1985):

"the preemptive scope of ERISA is neither all encompassing, *Lane v. Goren*, 743 F.2d 1337, 1339 (9th Cir. 1984), nor unlimited, *Savings and Profit Sharing Fund of Sears Employees v. Gago*, 717 F.2d 1038, 1040 (7th Cir. 1983)."

and, again, in holding specifically that ERISA did not preempt New York's statutory limitation on hospital inpatient charges as applied to self-insured employee benefit plans (*id.*),

"The containment of hospital costs is an exercise of a State's police powers, which should not be superseded by federal regulations unless that was

the clear intent of Congress [citations omitted]. Accordingly, a State's promulgation of hospital rate schedules should not be found to 'relate' to 'the terms and conditions of employee benefit plans' unless this conclusion is unavoidable."

In important decisions subsequent to *Metropolitan Life*, this Court has made it clear that the question of where the line is to be drawn should turn on a fair consideration of the historical context, and of whether the Congressional purposes manifested in ERISA would be aided or subverted by interpreting the preemption provision to be applicable. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (holding that a Maine statute mandating a one-time severance payment in the event of a plant closing did not "relate to any employee benefit plan"); and *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988).

*Mackey* decided that ERISA does not preempt Georgia's general garnishment law and hence does not prevent creditors of ERISA welfare benefit plan participants from bringing garnishment proceedings against the plan in order to collect judgments against plan participants. In reaching this conclusion this Court said (486 U.S. at 834)

"state-law methods for collecting money judgments must, as a general matter, remain undisturbed by ERISA; otherwise, there would be no way to enforce such a judgment won against an ERISA plan. If attachment of ERISA plan funds does not 'relate to' an ERISA plan in any of these circumstances, we do not see how respondent's proposed garnishment order would do so."

The Court carefully distinguished this general garnishment law from a special exemption the Georgia legislature had enacted which applied solely to ERISA employee benefit plans and which exempted them from

garnishment; that exemption statute the Court held was preempted by ERISA since it was specifically designed to affect employee benefit plans (486 U.S. at 829-830). In view of the distinction which the Court has thus drawn, it is important to note that the antisubrogation provision of the Pennsylvania Motor Vehicle Responsibility Law involved in the present litigation is not specially designed to apply to ERISA employee benefit plans, but is general legislation generally applicable.

Petitioner complains that the Pennsylvania antisubrogation law prohibits petitioner from exercising its subrogation rights (Pet. Br. 11). But the fact is that by virtue of this general Pennsylvania legislation, which is generally applicable to motor vehicle accident cases, petitioner does not have any such subrogation rights, and it is the strong public policy of Pennsylvania to prevent those in petitioner's position from evading the antisubrogation law by seeking to create such subrogation rights where none exist. It is no more appropriate for a self-insured benefit plan to seek to nullify such generally applicable Pennsylvania legislation than it would be for a self-insured benefit plan to seek to reinject a fault criterion into automobile accident cases in States which have enacted generally applicable no-fault laws. The reach of ERISA's preemption should not, and does not, stretch to such extremes.

Particularly in the light of the teachings of *Mackey*, it would appear that here the Third Circuit was too quick in rejecting the contention (which AOA supports) that the antisubrogation provision of the Pennsylvania Motor Vehicle Financial Responsibility Law does not "relate" in the ERISA sense, and that hence for this reason the ERISA preemption clause is inapplicable. But in any event, and however the Court may now decide to treat this question, we urge that care be taken to avoid any intimation which might impair or cast a cloud on the

validity of any of the widely-enacted State freedom of choice legislation.

It should be noted, moreover, that a considerable segment of the State freedom of choice legislation relating to vision care—some of it pertaining to insured plans only, some of it pertaining to plans not incorporated into insurance policies, and some of it pertaining to both—was enacted during the 1960s, long before ERISA was passed in 1974.<sup>3</sup> Hence the total absence, in ERISA's legislative history, of any suggestion that Congress intended to preempt this well-known mass of freedom of choice legislation adds much weight to the other reasons for concluding that no such preemption has occurred.

With respect to vision care, the freedom of choice laws are aimed at protecting people by assuring that more widespread vision care is available, by safeguarding the patient's freedom of choice, and indeed by discouraging monopolistic or restrictive practices—whether indulged in by insurance companies or by employers or by unions or by others. Such monopolistic practices would tend to channel away from optometrists, and in to physicians, the professional responsibility for and the revenue from the performance of vision care services which otherwise

<sup>3</sup> Such freedom of choice legislation relating to vision care dating from the 1960s is to be found in at least 24 States—namely, Alabama, Arizona, California, Colorado, Hawaii, Idaho, Indiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, Oklahoma, Oregon, South Dakota, Tennessee, Utah, Washington, West Virginia—and from 1970 through 1973 in at least 10 additional States—namely, Arkansas, Florida, Kansas, Kentucky, Louisiana, Missouri, Nevada, New Mexico, New York, Virginia. (This is apart from the considerable body of freedom of choice legislation dating from those periods and relating to branches of health care other than vision care.) Accordingly, much of the freedom of choice legislation not only antedates the enactment of ERISA in 1974 (P.L. 93-406, September 2, 1974), but will be found well before 1970.



would flow to optometrists. Compare *Blue Shield of Virginia v. McCready*, 457 U.S. 465 (1982).

This Court emphasized in *Fort Halifax*, supra, 482 U.S. at 11, that the Congressional purpose in adopting the preemption provision was to assist in achieving uniformity in the administration of an employee benefit plan having multi-state scope. In view of the fact that, with at most some minor variations, State freedom of choice legislation is universally present in the 50 States and the District of Columbia, no significant administrative diversity or complexity will be imposed by acknowledging that ERISA has not preempted any of the State freedom of choice statutes.

AOA's position—which AOA urges should be fully protected against dilution or impairment—was further confirmed within Congress during the enactment of the ERISA amendments known as the Multiemployer Pension Plan Amendments Act of 1980, P.L. 96-364, codified as 29 U.S.C. §§1001a et seq. During the final stages of that bill's passage in the House, Congressman Thompson (who was Chairman of the House Subcommittee on Labor-Management Relations and was piloting the bill through the House debates and was later one of the House Managers in the Conference Committee) stated (126 Cong. Rec. 23042, August 25, 1980):

"Finally, the distinguished gentleman from Texas, Representative Frost, has asked me to clarify the effect of ERISA's preemption provision on a state law requiring that health insurance contracts written in that state must provide covered persons the option to choose the specialist of their choice or must provide that the services of a particular specialist must be covered by the insurance contract if that patient chooses to go to that specialist. It is clear that ERISA does not preempt such a law,

which does not require that particular benefits be provided and therefore does not cause any cost-creating State law conflicts that preemption was intended to prevent. For example, a State law requiring that podiatrist, chiropractor, or optometrist services be covered by health insurance contracts if a person chooses to have a particular service performed by a podiatrist, chiropractor, or an optometrist, is not preempted."

While the views of a later Congress on such matters are not necessarily controlling, see *Mackey*, supra, 486 U.S. at 839-840, the foregoing statement from the pertinent Congressional leadership furnishes strong confirmatory support to AOA's position on this precise issue.<sup>1</sup>

<sup>1</sup> In the event that the question of preemption of State freedom of choice laws were to be directly litigated, there are at least two additional independent grounds supporting AOA's position that no such preemption exists.

First, preemption of the State freedom of choice laws would impair the federal antitrust laws and hence is expressly forbidden by ERISA itself in Section 514(d), 29 U.S.C. §1144(d), which provides that nothing in ERISA "shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States" (with certain specified exceptions not relevant here). Various employee benefit plans, both insured and self-insured, contain discriminatory and restrictive provisions having highly anticompetitive effects injurious to the public interest, which create lively and realistic opportunities for group boycotts and other seriously discriminatory practices. Such provisions offend not only the public policy and statutes of many States, but also the federal antitrust laws. *Blue Shield of Virginia v. McCready*, supra; accord, *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), certiorari denied, 450 U.S. 916 (1981); *Wilk v. American Medical Ass'n*, 895 F.2d 352 (7th Cir. 1990); compare *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 457-465 (1986). The freedom of choice laws stand as a bulwark against those who would otherwise commit serious violations of the federal antitrust laws. If ERISA were to be interpreted as preempting the State freedom of choice

## II

Even if the antisubrogation provision in the Pennsylvania Financial Responsibility Law were held to be—or were assumed to be—a law which “relates” in the ERISA sense, there would then be the questions which were next addressed by the Third Circuit. Is this law one which “regulates insurance” within the meaning of ERISA’s insurance savings clause? On this there has been no con-

laws, it could hardly be doubted that there would be a serious impairment of the federal antitrust laws and of the policies which the federal antitrust laws espouse. Harmonious reading of ERISA as a whole should surely lead to the non-preemption result. Compare *Shaw*, supra, 463 U.S. at 102, holding that State fair employment laws are so important to the federal Title VII statute (of the Civil Rights Act of 1964) that such State laws are not preempted by ERISA.

Second, preemption of the State freedom of choice laws would also impair the 1986 federal Medicare law amendment relating to optometry, and hence for this additional reason is expressly forbidden by the same provision in Section 514(d), 29 U.S.C. §1144(d) of ERISA itself. Until the 1986 Medicare amendment, most services rendered by optometrists were not a subject for Medicare reimbursement, even though the services were authorized to be performed by an optometrist under applicable State law and even though such services when rendered by an ophthalmologist were reimbursable. However, Section 9336 of P.L. 99-509 amended Clause (4) of Section 1861(r) of the Social Security Act, 42 U.S.C. §1395x(r), to put the services furnished by optometrists on a totally equal footing, for Medicare reimbursement purposes, with those furnished by ophthalmologists, to the extent that the services fall within the lawful scope of the practice of optometry. This amendment firmly established a federal statutory policy of nondiscrimination and equal treatment with respect to services rendered by optometrists in the field of vision care. This federal statutory policy had been foreshadowed, with respect to the policy of nondiscrimination and freedom of choice, by two items of earlier legislation relating to federal employees (P.L. 93-363, adding what is now 5 U.S.C. §8902(k); and P.L. 93-916, amending 5 U.S.C. §8101(2) and (3)), which were enacted in 1974 by the same Congress which enacted ERISA.

troversy, and none should be generated in this Court. The Third Circuit noted that (885 F.2d at 85; Pet. A16)

“Both parties and the amicus agree that the type of antisubrogation provision found in the Pennsylvania Financial Responsibility Law ‘regulates insurance’ within the meaning of the savings clause.”

The Third Circuit correctly concluded that this is plainly so (885 F.2d at 85-86; Pet. A16).

## III

Hence the Third Circuit moved on to the next question: Where the plan is self-insured, does the deemer clause take the antisubrogation provision of the Pennsylvania Motor Vehicle Financial Responsibility Law out from under the insurance savings clause and put it over into the preempted category? On this issue the Third Circuit’s opinion (885 F.2d at 86-90; Pet. A18-A27) sets forth a remarkably clear and careful exposition of the relevant legislative history. Despite petitioner’s unpersuasive effort to brush aside the details of the legislative history (Pet. Br. 26-27), the Third Circuit’s recital is an accurate reflection of what really occurred during the preemption provision’s journey through Congress. It reaches a conclusion which, we submit, comports with the structure and purposes of ERISA as well as its language. Specifically, the Third Circuit’s analysis has led it to the conclusion that, with respect to self-insured plans, the proper meaning of the deemer clause is that the deemer clause is intended to cause preemption when the State regulation involved affects a central concern of ERISA but not when it does not affect a central concern of ERISA, and that since the Pennsylvania antisubrogation law is in the latter category the deemer clause does not apply and accordingly the Pennsylvania law is not preempted. To put the matter another way, the Third Circuit has

held that "the deemer clause guards against any insurance regulation that infringes on such ERISA areas as reporting, disclosure, and nonforfeitability" (885 F.2d at 88; Pet. A23), and that Pennsylvania's antissubrogation law does not involve any such infringement.

The fact that the Third Circuit's careful analysis led it to bypass (885 F.2d at 89; Pet. A24-A26) a dictum which appears in this Court's opinion in *Metropolitan Life*, supra, does not in any way detract from the correctness of the Third Circuit's analysis. If all dicta were binding, the law would be paralyzed beyond repair; this Court has often recognized the propriety—and indeed the necessity—of revisiting dicta when a point later becomes actually in issue. See, for example, *Cohens v. Virginia*, 6 Wheat. 264, 399-400 (1821); *Green v. United States*, 355 U.S. 184, 197 note 16 (1957); *McDaniel v. Sanchez*, 452 U.S. 130, 141 (1981); *United States v. Halper*, 109 S.Ct. 1892, 1903 note 11 (1989).

## CONCLUSION

For the reasons we have summarized, the Third Circuit's judgment should be affirmed. In any event—and no matter how this Court decides to deal with the issues raised—the Court is urged to avoid any decision route which would impair or cast a cloud upon any of the State freedom of choice legislation which is so important to the Nation's welfare.

Respectfully submitted,

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May 9, 1990

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**BEST AVAILABLE COPY**

**QUESTION PRESENTED**

Whether ERISA preemption exempts self-funded or self-insured employee benefit plans from state insurance statutes enforceable against insured employee benefit plans and licensed insurance companies, where such statutes are neither directed specifically to employee benefit plans nor core ERISA provisions.

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IN THE  
**Supreme Court of the United States**  
OCTOBER TERM, 1989

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**No. 89-1048**

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FMC CORPORATION,

*Petitioner,*

v.

CYNTHIA ANN HOLLIDAY,

*Respondent.*

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**On Writ Of Certiorari To The  
United States Court Of Appeals  
For The Third Circuit**

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**BRIEF AMICUS CURIAE OF  
AMERICAN PODIATRIC MEDICAL ASSOCIATION  
IN SUPPORT OF RESPONDENT**

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The American Podiatric Medical Association submits this brief *amicus curiae* in support of respondent. Letters granting consent, received from counsel for each of the parties, are being filed together with this brief.

**STATEMENT OF INTEREST OF AMICUS CURIAE  
AMERICAN PODIATRIC MEDICAL ASSOCIATION**

The American Podiatric Medical Association (APMA) is a voluntary membership association rep-

representing over 9,000 licensed doctors of podiatric medicine practicing in each of the 50 states, Puerto Rico and the District of Columbia. Podiatry, or podiatric medicine, is regulated in each of the fifty states as a recognized healing art, along with medicine, osteopathy, dentistry, optometry, and other licensed providers of health care. In some jurisdictions, podiatric medicine is regulated by independent statute; in others, licenses are granted pursuant to the medical practice act which likewise regulates the practice of medicine.<sup>1</sup> APMA is a District of Columbia non-profit corporation with its principal office in Bethesda, Maryland. APMA exists as a confederation of state podiatric medical associations.

An estimated nine and one half million Americans receive their health care benefits from self-funded welfare benefit plans.<sup>2</sup> Many such plans provide benefits for foot care. However, some of these plans, together with traditional insurance contracts contain benefit provisions excluding or restricting the coverage of podiatry; i.e., distinguishing between podiatric physicians and other licensees authorized to care for the human foot. This discrimination against podiatrists led to the enactment of state "freedom of choice" or "non-discrimination laws" requiring that third party payment of health care costs be determined without regard to the degree or license held, provided that the service rendered was within the scope of such practitioner's license. It is the position of APMA that this Court's opinion in the instant case

<sup>1</sup> See for example, Code of Virginia, Section 54.1 - 2929, et. seq.

<sup>2</sup> See Petitioner's brief, p.4 n.2 citing U.S. Dept. of Labor, Bureau of Labor Statistics, Bulletin 2336 (August 1988).

will likely decide questions which will have a significant effect on the applicability of "freedom of choice" and "non-discrimination laws" to employee welfare plans. Thus, as the national organization representing the interest of doctors of podiatric medicine, APMA hereby respectfully submits this brief *amicus curiae* in support of the brief of respondent, Cynthia Ann Holliday and the Third Circuit's holding in this case. APMA further submits that this Court's disposition of the instant case should not adversely affect, and should in fact reaffirm, the efficacy of "freedom of choice" laws as unimpaired by the preemption provision of ERISA.

#### SUMMARY OF ARGUMENT

This case deals with the applicability of state insurance laws to self-funded employee benefit plans. Specifically, the Court is being asked to consider whether the Pennsylvania Motor Vehicle Financial Responsibility Law is enforceable against such plans. The answer lies in the meaning of Section 514 of ERISA, 29 U.S.C. Sec. 1144: 1) is the state law preempted by ERISA? 2) is the state law "saved" from preemption? and 3) does the "deemer" clause excuse self-funded plans from compliance with the state law?

The initial focus in ERISA preemption cases has been whether the state law "relates" to employee benefit plans. A law may have so indirect an effect on such plans as to fall outside the scope of the "relates to" test. The Pennsylvania anti-subrogation and "freedom of choice" statutes are laws directed to all applicable third party payers and not specifically di-

rected to employee benefit plans. The anti-subrogation law poses no true burdens on the administration of employee benefit plans and conflicts with no ERISA provisions. Nevertheless, the Court of Appeals has noted that the anti-subrogation law is a law relating to the plan and is a law regulating insurance. The outcome of this case rests on the scope of the "deemer" clause. The Third Circuit has, after consideration of precedent, legislative history and common sense, concluded that the deemer clause provides a narrow exception to the application of insurance laws to self-funded employee benefit plans. The savings clause permits the states to enforce the insurance laws notwithstanding general ERISA preemption. That a self-funded plan should not be "deemed" an insurance company for purposes of any insurance law regulating insurance companies or insurance contracts should, in no way, interfere with a state's right to enforce its insurance laws. The deemer clause refers to a narrower set of laws than *all* insurance laws saved from preemption and applies only to such state statutes which directly or deliberately conflict with central provisions of ERISA. Anti-subrogation laws as well as "freedom of choice" laws are saved from preemption and do not relate to core ERISA provisions so as to be inapplicable to self-funded plans.

#### ARGUMENT

**State insurance laws must bear a relation to employee benefit plans so as to be preempted by ERISA.**

- I. State "freedom of choice" laws do not "relate" to employee benefit plans and thus, are not preempted by ERISA.

This case deals primarily with the scope of insurance laws saved from federal preemption pursuant to

ERISA section 514 (b)(2)(A) and the limitations on enforcement of such insurance laws by the "deemer" clause of ERISA section 514 (b)(2)(B). Earlier cases have dealt with the three-pronged ERISA preemption concept; namely, whether a state law sufficiently "relates" to benefit plans as to be superseded by ERISA (29 U.S.C. section 1144 (a)), whether the state law is a law which "regulates insurance" and is thereby saved from preemption (29 U.S.C. Section 1144 (b)(2)(A)), and whether the plan to which the state law is being applied is being "deemed" to be an insurance company or other insurer or to be engaged in the business of insurance for purposes of any law purporting to regulate insurance companies or insurance contracts, (29 U.S.C. Section 1144 (b)(2)(B)).

Typically, ERISA preemption analysis commences with a determination of the state law's relationship to employee benefit plans. The Third Circuit in the instant case, citing this Court, determined that a "law relates to an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such plan." *FMC Corporation v. Holiday*, 885 F.2d 79, 84, (3rd Cir. 1989), citing *Shaw v. Delta Airlines*, 463 U.S. 85, at 96, 97, 103 S.Ct. 2890 at 2900, 77 L.Ed. 2d 490, (1983). In *Shaw*, this Court ruled that New York's Disability Benefit and Human Rights laws "related" to employee benefit plans. Nevertheless, this Court observed that certain "state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21, 103 S.Ct. at 2901 n.21.

In *Holliday*, the Third Circuit held that the Pennsylvania anti-subrogation law "related" to employee



benefit plans and would have been preempted, absent the applicable "savings clause" concerning state insurance laws. Petitioner's broad interpretation results in a lack of uniform application of state laws providing the public with equal access to and reimbursement for health care services rendered by any licensed practitioner.<sup>3</sup> APMA believes, these "freedom of choice" laws relate to employee benefits, but not to employee benefit plans. This distinction was recently discussed and set forth by this Court in *Fort Halifax Packing v. Coyne*, 482 U.S. 1, 107 S.Ct. 221, 96 L.Ed. 2d 1, (1987), wherein it was held that a Maine law prescribing severance payments in the event of plant closings was not a law relating to employee benefit plans, but a law relating only to employee benefits. Similarly, "freedom of choice" laws do not relate to employee benefit plans; rather they merely provide that, if a particular health condition is subject to reimbursement by whatever agreement the individual has established, any licensed provider shall be entitled to reimbursement for any service performed within the scope of the provider's license. APMA agrees with *amicus* American Optometric Association (AOA) that

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<sup>3</sup> Numerous states have enacted laws to protect the right of equal reimbursement for medical services rendered by a podiatrist or medical doctor; for example, in Pennsylvania, "[n]otwithstanding any provision or any policy of insurance, self-insured sickness health and/or welfare plan providing benefits issued or renewed after the effective date of this act, whenever such policy or plan provides for reimbursement for any service which may be legally performed by a person licensed under the laws of the Commonwealth for the practice of medicine, osteopathy . . . [or] podiatry . . . reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed." 40 Pa. Stats. at 1511.

such laws "are outside the scope of ERISA's preemption clause." AOA brief, p. 9. These laws, contrary to the Massachusetts law considered in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) do not mandate that a particular service be covered, do not force the employer to haphazardly provide for a particular service and do not require any modification to the administrative procedures of any employee benefit plan. "Freedom of choice" laws do not "establish a plan . . . generate . . . no program activity that normally would be subject to ERISA regulation. . . . [pose] no risk either that an employee will evade or that a state will dislodge otherwise applicable federal regulatory requirements. Nor is there any prospect that an employer will face difficulty in operating a unified administrative scheme for paying benefits." *Fort Halifax Packing Company v. Coyne*, 482 U.S. at 15.

APMA firmly believes that, like "freedom of choice" laws, the Pennsylvania anti-subrogation law is too "tenuous, remote or peripheral" [*Shaw* 463, U.S. at 100 n.21] to fall within ERISA's scope of preemption, meant to minimize interference with the administration of employee benefit plans.

Nevertheless, assuming the Supreme Court determines now, or at some future time that "freedom of choice" laws "relate to" ERISA plans, APMA agrees with respondent and the Third and Sixth Circuits that, notwithstanding the "deemer" clause, certain insurance laws "saved" from preemption apply to self-insured employee benefit plans.

**II. The "deemer" clause does not preclude state regulation of self-insured employee benefit plans as to all state insurance laws otherwise saved from preemption.**

Assuming, the Third Circuit was correct in holding the preemption provisions of ERISA applicable to state subrogation laws, there remains the analysis of the "savings" and "deemer" clauses (29 U.S.C. Section 1144 (b)(2)(A) and 29 U.S.C. Section 1144 (b)(2)(B)). This case essentially arises from conflicting interpretations of these ERISA provisions. The petitioner asserts that ERISA preempts self-funded benefit plans, such as that operated by FMC, from state insurance laws because the ERISA "savings" clause does not apply to self-insured plans pursuant to the "deemer" clause.

In support of this broad interpretation of the "deemer" clause, petitioner relies on *Metropolitan Life Insurance Co. v. Massachusetts*, as the basis for the distinction between self-insured plans and insured plans. Specifically, the petitioner cites this Court's observation that its decision in *Metropolitan Life* results in a distinction between insured and uninsured plans leaving the former open to indirect regulation while the latter are not. *Metropolitan Life*, 471 U.S. at 747. The Third Circuit, on the other hand, determined that this inconsistent treatment of insured and self-insured employee benefit plans merely meant that while

under *Metropolitan Life* [,] insured plans would *per se* survive the deemer clause. . . self-insured plans would merely be considered on a case by case basis as to

whether the state regulation involves a central concern of ERISA.

*FMC Corp. v. Holliday*, 885 F.2d 79, 89 citing *Northern Group Services Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), cert. denied, 108 S.Ct. 1754 (1988).

In essence, petitioner argues that, as a consequence of the deemer clause, a state "may not directly or indirectly regulate a self-funded employee benefit plan that does not purchase any insurance products." (Petitioner's brief, p. 16). Petitioner has misinterpreted the deemer clause and, consequently, the true intent of this Court's observation in *Metropolitan Life*. Rather than exclude self-insured plans from all insurance laws, "[t]he deemer clause protects ERISA plans from being deemed insurers, or otherwise in the business of insurance by any state law 'purporting' to regulate insurance companies or insurance contracts." *FMC v. Holliday*, 855 F.2d 86, 87. Summarizing the three-pronged ERISA preemption test, the Third Circuit concluded that

the preemption clause preempts nearly any state law relating to employee benefit plans, second, the savings clause carries out the narrow but sizable exception of state laws regulating insurance; and finally, the deemer clause guards against any insurance regulation that infringes on such ERISA areas as reporting, disclosure, and nonforfeitability.

*FMC v. Holliday*, 885 F.2d 88. The appellate court properly distinguishes between what is "saved" by 29 U.S.C. Section 1144 (b)(2)(A) and what is to be protected by the "deemer" clause (29 U.S.C. Section

1144 (b)(2)(B)). A close look at the two provisions reveals that the savings clause protects from preemption "any law of any state which regulates insurance" (emphasis added)." The deemer clause, on the other hand, narrowly protects self-insured plans from those laws purporting to regulate insurance companies or insurance contracts. Health insurance has been defined as

A contract or agreement whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks.

*Blacks Law Dictionary*, 5th Ed (1979), pp. 722-723. This is precisely what the FMC plan provides (see petitioner's brief, p.4 n.1). An insurance contract is the policy of insurance entered into between two parties. "A policy of insurance is the written instrument in which a contract of insurance is set forth." *Id.*, p. 1042. Thus, the "savings" clause saves from preemption state laws regulating the insurance concept while the "deemer" clause protects self-insured plans from state laws regulating the policy itself. This distinction was recognized by the Sixth Circuit's holding in *Northern Group Services*, that a state no-fault coordination of benefits law, requiring insurers to offer certain benefit provisions, was saved from preemption and not subject to the deemer clause as applied to self-funded plans. (*Id.*, 833 F.2d 85). The plans contained coordination of benefit provisions seeking to

make the liability of the employee benefit plans secondary to state mandated no-fault automobile insurance. The plan provisions were in conflict with the state law which "mandates that no-fault carriers offer coordination of benefits at reduced premiums when the insured has other health and accident coverage." Mich Comp. Laws Section 500.3109a.

Petitioner does not contest the district and appellate court determinations that the Pennsylvania Statute "regulates insurance within the meaning of the insurance savings clause" (Petitioner's brief, p. 13, citing *FMC*, 885 F.2d 86). The scope of what is encompassed by the "savings clause" is illustrated by this Court's statement that a court "must presume that Congress did not intend to preempt areas of traditional state regulation." *Metropolitan Life*; 471 U.S. at 740, 105 S.Ct. at 2389. It has been well-established that state regulation of insurance goes beyond the so-called "business of insurance" governed by the McCarran-Ferguson Act, 15, U.S.C. Section 1011 et. seq. (1976). This Court has held that

many aspects of insurance companies are regulated by state law, but are not the "business of insurance" . . . state regulation of a practice of an insurance company does not mean that the practice is the "business of insurance" within the meaning of the McCarran-Ferguson Act.

*Group Life and Health Insurance v. Royal Drug Co.*, 440 U.S. 205 (1979).

As noted by the Sixth Circuit, this Court "construed the sweep of the savings clause as a whole and in light of the object and policy underlying



ERISA, thus going beyond the meaning imposed merely by application of the McCarran-Ferguson Act factors." *Northern Group Services*, 833 F.2d 94, n.6 citing *Pilot Life Insurance Co. v. Dedaux*, 481 U.S. 41 (1987).

Thus, "begin[ning] with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses legislative purpose" *Metropolitan Life*, 471 U.S. 740, (citation omitted), ERISA "saves" more for state regulation than it takes back with the "deemer" clause.

The Sixth Circuit in *Northern Group Services*, recognizing that the "legislative history behind the deemer clause is ambiguous," concluded that "for the deemer clause to override the savings clause in a given case, there must be some ERISA interest in uniformity to outweigh the McCarran-Ferguson interest in state regulation of insurance." Clearly, ERISA is devoid of any language identifying an interest in no-fault insurance, subrogation, or "freedom of choice" laws. Petitioner's contention that Congress intended to save insured plans from preemption while excluding self-insured plans from non-ERISA related state insurance laws suggests that Congress envisioned the "patchwork scheme of regulation" feared by this Court in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, where the Court stated that

Congress intended preemption to afford employers the advantages of a uniform set of administrative proceedings governed by a single set of regulations. This concern only arises, however, with respect to benefits whose provisions by nature require an on-

going administrative program to meet the employer's obligation.

*Fort Halifax Packing Co. v. Coyne*, 482 U.S. 11.

Petitioner's argument further suggests that employee benefit plans may be treated differently with respect to state insurance laws solely on the basis of whether such a plan is self-insured or commercially insured. APMA agrees with the Third Circuit that

the proper inquiry under the deemer clause is whether the state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect. . . . The Court reviewing a state insurance law, should inquire whether that law conflicts with any substantive mandate in ERISA.

*FMC v. Holliday*, 885 F.2d 89, 90.

Said another way, the deemer clause does no more than prevent the states from applying certain insurance laws, i.e., those pertaining to the "business of insurance" and "insurance contracts" to self-funded employee benefit plans. Nevertheless, other forms of insurance regulation remain "saved" from the preemption provisions of ERISA.

#### CONCLUSION

APMA submits that certain state insurance laws remain "saved" from ERISA preemption, either because such laws do not "relate" to ERISA so as to be preempted, or, alternatively, such laws are insurance laws, applicable to all employee benefit plans. The deemer clause applies only in such cases where

the state seeks to override a true ERISA interest. State statutes which have declared a broad public policy of prohibiting reimbursement discrimination against particular classes of health care practitioners persuasively illustrate the importance of preserving this distinction.

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IN THE  
**Supreme Court of the United States**  
OCTOBER TERM, 1989

FMC CORPORATION,

*Petitioner,*

v.

CYNTHIA ANN HOLLIDAY,

*Respondent.*

On Writ of Certiorari to the United States  
Court of Appeals for the Third Circuit

**BRIEF OF AMICUS CURIAE  
THE AMERICAN CHIROPRACTIC ASSOCIATION  
IN SUPPORT OF RESPONDENT,  
CYNTHIA ANN HOLLIDAY**

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BRIEF OF AMICUS CURIAE  
THE AMERICAN CHIROPRACTIC ASSOCIATION  
IN SUPPORT OF RESPONDENT,  
CYNTHIA ANN HOLLIDAY

---

**INTEREST OF AMICUS CURIAE**

The American Chiropractic Association ("ACA") represents 18,000 doctors of chiropractic from all across the nation.<sup>1</sup> The ACA seeks to promote chiropractic as a heal-

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<sup>1</sup> The American Chiropractic Association has obtained the written consent of both FMC Corporation and Cynthia Ann Holliday to the filing of this amicus curiae brief. Original consent letters from the parties have been lodged with the Court.

ing profession and to serve as a spokesperson for the chiropractic profession in the United States. The question presented by this case—whether ERISA preempts application of a state anti-subrogation law to an employee benefit plan—is of great concern to all ACA members, their patients who participate in ERISA plans, and indeed, *all* health care consumers in the United States.

Health care costs are out of control. This should not be surprising since the 'invisible hand' of free market competition has long been paralyzed in the health care market. Decades of medical physician-dominance and control of the market have resulted in substantial exclusion of competitive, licensed health care providers in the largest sector of the health care market, especially in the area of health care insurance. For these and other reasons, many states have enacted insurance equality laws which require insurers to pay for services rendered by competitive health care providers such as chiropractors and podiatrists to the same extent "payment for the same services" would be made to medical physicians. In other words, the act does not mandate service—it mandates equality of insurance coverage notwithstanding the licensed providers of the service.

An interpretation of ERISA that would preempt application of these critically important state laws despite their lack of any impact whatsoever on any core ERISA concern, would not only harm all ACA members and their patients, but also greatly reduce any chance for competition among different types of health care providers in a huge portion of the health care market in this country.

## SUMMARY OF THE ARGUMENT

ERISA's deemer clause, 29 U.S.C. §1144(b)(2)(B), should be interpreted to accommodate vital state interests in correcting serious problems in the health care insurance industry where the state laws in furtherance of that interest do not conflict with any ERISA provision or regulate areas already regulated by ERISA. Otherwise, state laws that enhance competition, reduce health care costs, and provide consumers with a modicum of freedom of choice will be void in a large segment of the immense and growing health care market governed by ERISA plans. Nothing in the legislative history of ERISA suggests that Congress intended the deemer clause to be read as a total bar to the application of such important state insurance laws to employee benefit plans. The deemer clause thus should not be read to provide such a draconian and unreasonable result.

## ARGUMENT

### I. Insurance Equality Of Licensed Provider Laws Provide Essential Competition And Freedom Of Choice Among Health Care Providers To Patients With Third Party Coverage

The cost of health care in this country is skyrocketing out of control. Health care costs jumped from 75.0 billion dollars, or 7.4 percent of GNP in 1970, to 458.2 billion dollars, or 10.9 percent of GNP in 1986. STATISTICAL ABSTRACT OF THE UNITED STATES, p. 90 U.S. Dept. of Commerce (1989). The country spent almost a half *trillion* dollars on health care, more than 11 percent of GNP in 1988. Health and Medical Services, U.S. Dept. of Commerce, *U.S. Industrial Outlook 1988*, 58-1 (1988).

Many commentators have come to the conclusion that one of the most important causes of the problem is the medical physician monopoly over health care, including health care insurance and financing.

Physicians, not institutions, control the vast bulk of health care expenditures. Doctors determine when, how long, how intensively, and in what environment to treat patients. They order the laboratory tests, x-rays, pharmaceuticals, and surgery that determine the short-term institutional costs of treatment and that ultimately create the long-term demand for capital resources and insurance coverage. Although difficult to qualify with precision, informed estimates place 70 to 90 percent of health care expenditures within the control of individual practitioners.

In order for health care cost containment to succeed, then, it is necessary for those institutions that employ, retain, or house doctors to implement new managerial control techniques that alter treatment behavior. Effective institutional control strategies, however, are unlikely to fit well within a legal structure that has evolved under a traditional, unrestrained reimbursement environment in which physician interests and authority have predominated.

Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 434 (1988). See Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303, 304-05 (1978) (a "root cause" of problems in health care cost containment "has been the [medical] profession's long-standing resistance to economizing innovations in the organization and administration of private plans for financing health care").

Through enormous power maintained by a variety of complex and subtle structural mechanisms, medical physi-

cians exercise a great deal of control of third party payment systems and who shall compete within them:

... the profession's power, resulting not only from a surprising degree of consensus within the profession but also from a complex network of frequently subtle but always substantial controls and influences, has conditioned all actors in the health care system and effectively deterred all but the most modest attempts at change.

Hall, 1978 DUKE L.J. at 319.

One mechanism of medical physician control of health care financing is the "profession-dominated financing plan, such as Blue Shield or a county medical service bureau." *Id.* at 311. Commercial plans have followed suit:

The commercial companies often operate at a distinct disadvantage in competition with the "Blues" [Blue Cross and Blue Shield]. Their competitive disadvantage and their vulnerability to boycotts [by medical physicians] appear to have caused the commercial insurers to accept the Blues' leadership on matters about which providers [medical physicians] feel strongly and to direct their competitive efforts elsewhere.

*Id.* at 338.

The monopolistic structure of the market has allowed medical physicians to control health care ideology and competitive health care providers. As Professors Havighurst and King have explained:

The current organization and operation of the health care industry reflect the continued strength of the view that it should function as a single, essentially monopolistic system. Although no formal monopoly exists and many of the system's monolithic features have begun to break down, the medical profession



still maintains significant control or influence at points where an outbreak of ideological diversity and decentralized decision making would threaten the [monopolistic] system's integrity. Because the antitrust laws now deny the [medical] profession the full range of formal controls that would be needed to manage the system completely, some diversity inevitably exists and is increasing. Yet, in practice, a high degree of standardization is still maintained, in large measure by virtue of a monopolistic ideology that contemplates that change should come not from independent entrepreneurial activity but from within the system as a matter of professional policy or negotiated consensus. The most intricate and complete mechanism for standardizing system inputs is that governing the training and labeling of personnel produced for service in the system.<sup>2</sup>

C. Havighurst & N. King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective*, 9 AM. J. L. & MED. 263, 266-67 (1983).

<sup>2</sup> For an example of medical physician control of ideology and competition through powerful physician-dominated organizations such as the Joint Commission on Accreditation of Hospitals ("JCAH"), see *Wilk v. American Medical Ass'n*, 895 F.2d 352 (7th Cir. 1990), cert. denied, \_\_\_ U.S. \_\_\_ (June 11, 1990). As Professor Hall has explained in great detail, the JCAH accreditation standards are "powerfully influential." 137 U. PA. L. REV. at 527.

JCAH standards decree an organized medical staff whose by-laws "establish a framework for self-governance." Notably the medical staff must have substantial authority over membership selection: it alone conducts the credentialing process that is the basis for determining admitting and treating privileges.

Even without this statutory imprimatur, the JCAH, as the sole hospital accrediting organization, effectively has plenary authority over the structure of American hospitals. See Havighurst & King, *supra* . . . , at 323. Almost no hospital of significant size will risk the business consequences of operating without its seal of approval.

*Id.* at 529-530.

This entrenched, systematic control and exclusion of competitive health care providers has obviously reduced price and product or service competition in the health care market.

Unfortunately, competition in health services has not focused enough on values, preferences, costs, or alternative ideas about how health needs should be met. Instead, because of the dominance of a single profession-sponsored ideology [of medical physicians], health care competition has concentrated primarily on the amenities surrounding the provision of an essentially uniform product.

*Id.* at 265. (emphasis added). This type of restriction in competition not only "deprive[s] individuals of the opportunity to obtain a desirable professional position" and "increase[s] the cost of medical services in an artificial and unnecessary way," but also greatly reduces consumers' freedom of choice. See Kissam, *Government Policy Toward Medical Accreditation and Certification: The Antitrust Laws and Other Procompetitive Strategies*, 1983 WIS. L. REV. 1, 16.

Thus, the only way cost containment will come about is by breaking the medical physicians' grip on the health care market and opening it up to competition:

Cost containment pressures will not relent until [medical] physicians have undergone a revolutionary change in behavior.

. . .

For decades, physicians have enjoyed essentially unfettered control over both medical practice and its workplace. Physicians gained control of access to medical practice at the turn of the century through licensing laws and medical education requirements that created a self-perpetuating, state-sanctioned monopoly. During the following quarter century, the medical

profession harnessed the hospitals through accreditation standards that assured costless and unrestricted use of these capital-intensive facilities essential to modern practice.

The hospital industry, marked by a much greater degree of uniformity than other sectors of the economy, is particularly ripe for organizational innovation. . . .

The [medical] profession's grip on the internal organization of hospitals must be broken in order for cost containment to succeed.

Hall, 137 U. PA. L. REV. at 443, 445-46, 505, 507.

Over the past 20 years, nearly every state has passed some type of "Equality of Provider" or "Freedom of Choice" law requiring insurers to pay for the services of non-medical physician health care providers,<sup>3</sup> to the extent

<sup>3</sup> Freedom of Choice insurance laws regulating health insurance policies have been adopted in nearly every state. *See* ALA. CODE at §27-1-10 (1975) (chiropractors); *Id.* at §27-1-11 (dentists); *Id.* at §27-19-39 (optometrists); *Id.* at §27-1-15 (Supp. 1989) (podiatrists); *Id.* at §27-1-18 (Supp. 1989) (psychologists and psychiatrists); ALASKA STAT. at §21.42.355 (1984) (nurse midwives); *Id.* at §21.89.040 (optometrists); ARIZ. REV. STAT. ANN. at §20-1406 (1984 & Supp. 1989) (optometrists, ophthalmologists, podiatrists, nurse practitioners, and licensed providers); *Id.* at §20-1406.01 (Supp. 1989) (psychologists and chiropractors); ARK. STAT. ANN. at §23-79-114 (1987) (optometrists, podiatrists, dentists, psychologists); CAL. INS. CODE at §10176 (West 1972 & Supp. 1989) (psychologists, social workers, counselors, speech pathologists, audiologists, registered nurses, psychiatric mental health nurses, chiropractors, dentists, podiatrists, opticians, optometrists, and occupational therapists); *Id.* at §10176.2 (physical therapists); COLO. REV. STAT. at §10-8-103(3)(a) (1973) (osteopaths, dentists, optometrists, psychologists, chiropractors, and podiatrists); CONN. GEN. STAT. ANN. at §38-174d (West Supp. 1990) (psychologists, psychiatrists, and social workers for child guidance clinics); *Id.* at §38-174h (dentists); *Id.* at §38-174q (occupational therapists); *Id.* at §38-174v (nurse midwives, nurse practitioners,

(Footnote continued on following page)

<sup>3</sup> continued

and psychiatric mental health clinical nurse specialists); DEL. CODE ANN. tit. 24, at §2101(c) (1981) (optometrists); *Id.* at §511 (Supp. 1988) (podiatrists); *Id.* at §717 (Supp. 1988) (chiropractors); FLA. STAT. ANN. at §627.419 (West 1988) (dentists, optometrists, podiatrists, and chiropractors); *Id.* at §627.6406 (nurse midwives); GA. CODE ANN. at §33-24-27(b) (1982) (psychologists and chiropractors); *Id.* at §33-24-27.1 (optometrists); HAW. REV. STAT. at §431-450 (1986) (optometrists); *Id.* at §431-499 (dentists); *Id.* at §431-500 (1986) (psychologists); IDAHO CODE at §41-2103 (1977) (podiatrists and optometrists); ILL. REV. STAT. ch. 73 at para. 976 (1989) (dentists); *Id.* at para. 976.1 (optometrists); *Id.* at para. 982b. (podiatrists); *Id.* at para. 982c. (psychologists); IND. CODE ANN. at §27-8-6-1 (Burns 1987) (dentists, health service providers in psychology, podiatrists, osteopaths, optometrists, and chiropractors); IOWA CODE ANN. at §509.3 (West Supp. 1990) (chiropractors, registered nurses, chiropodists); *Id.* at §514.7 (optometrists); KAN. STAT. ANN. at §40-2, 100 (1981) (optometrists, dentists, and podiatrists); *Id.* at §40-2, 104 (psychologists); KY. REV. STAT. §304.18-095 (Baldwin 1988) (optometrists, chiropractors & osteopaths); *Id.* at §304.18-097 (dentists); LA. REV. STAT. ANN. at §22:662 (West 1978) (podiatrists); *Id.* at §22:664 (optometrists); *Id.* at §22:665 (psychologists); *Id.* at §22:668 (chiropractors); *Id.* at §22:213.1 (West Supp. 1990) (dentists); *Id.* at §22:669 (social workers) (West Supp. 1990); ME. REV. STAT. ANN. tit. 24-A, at §2744 (Supp. 1989) (psychologists, social workers, and psychiatric nurses); *Id.* at §2748 (chiropractors); MD. ANN. CODE art. 48A, at §490 (1979) (podiatrists); *Id.* at §477-0 (1979 & Supp. 1989) (social workers); *Id.* at §477T (Supp. 1989) (nurse practitioners); *Id.* at §489 (Supp. 1989) (chiropractors); *Id.* at §490A (Supp. 1989) (psychologists); *Id.* at §490A-2 (Supp. 1989) (nurse midwives); MASS. GEN. LAWS ANN. ch. 175 at §108B (West 1987) (dentists); *Id.* at §110 (optometrists and podiatrists); *Id.* at §108D (chiropractors); MICH. COMP. LAWS ANN. at §500.2243 (West 1983) (optometrists); *Id.* at §500.3475 (psychologists, chiropractors, and podiatrists); *Id.* at §500.2239 (West Supp. 1990) (dentists); MINN. STAT. ANN. at §62A.043 (West 1986) (dentists and podiatrists); *Id.* at §62A.15 (optometrists, chiropractors, and registered nurses); *Id.* at §62A.152 (psychologists); MISS. CODE ANN. at §83-41-203 (1972) (optometrists); *Id.* at §83-41-209 (Supp. 1989) (dentists); *Id.* at §83-41-211 (Supp. 1989) (psychologists); *Id.* at §83-41-213 (Supp. 1989) (nurse practitioners); *Id.* at §83-41-215 (Supp. 1989) (chiropractors); MO. ANN. STAT. at §375.936(11)(b) (Vernon Supp. 1990) (optometrists, chiropractors, dentists, psychologists, pharmacists, and podiatrists); *Id.* at §354.027 ("person[s] duly licensed" to perform covered services); MONT. CODE ANN. at

(Footnote continued on following page)

<sup>3</sup> continued

§33-22-111 (1987) (dentists, osteopaths, chiropractors, optometrists, chiropractors, psychologists, social workers, nurse specialists, and pharmacists); NEB. REV. STAT. at §44-513 (1988) (osteopaths, chiropractors, optometrists, psychologists, dentists, and podiatrists); NEV. REV. STAT. at §689A.380 (1986) (dentists, osteopaths, chiropractors, oriental medicine, podiatrists, and optometrists); *Id.* at §689B.038 (psychologists); *Id.* at §689B.039 (chiropractors); N.H. REV. STAT. ANN. at §415:18-a (1983) (licensed pastoral counselors, psychologists, and psychiatrists); N.J. STAT. ANN. at §17B:27-50 (West 1985) (psychologists); *Id.* at §17B:27-51 (optometrists); *Id.* at §17B:27-51.1 (chiropractors); *Id.* at §17B:27-51.8 (dentists); N.M. STAT. ANN. at §59A-22-32 (Supp. 1989) (optometrists, psychologists, podiatrists, and nurse midwives); N.Y. INS. LAW at §3221 (McKinney 1985) (nurse midwives and social workers); *Id.* at §4235 (physical therapists, podiatrists, optometrists, dentists, psychiatrists, psychologists, and chiropractors); N.C. GEN. STAT. at §58-50-30 (1989) (optometrists, podiatrists, dentists, chiropractors, and psychologists); OHIO REV. CODE ANN. at §3923.23 (Page 1989) (osteopaths, optometrists, chiropractors, and podiatrists); *Id.* at §3923.231 (psychologists); *Id.* at §3923.232 (dentists); *Id.* at §3923.233 (nurse midwives); OKLA. STAT. ANN. tit. 36, at §6051 (West 1990) (optometrists); *Id.* at §3634 (podiatrists, psychologists, and clinical social workers); *Id.* at §6055 ("any practitioner" selected by the insured); PA. STAT. ANN. tit. 40, at §1511 (Purdon Supp. 1988) (osteopaths, dentists, chiropractors, podiatrists, and physical therapists); *Id.* at §3002 (nurse midwives); R.I. GEN. LAWS at §27-18-25 (1989); S.C. CODE ANN. at §38-71-200 (Law Co-op. 1989) (podiatrists, optometrists, and oral surgeons); *Id.* at §38-71-210 (chiropractors); S.D. CODIFIED LAWS ANN. at §58-17-53 (Supp. 1989) (optometrists); *Id.* at §58-17-54 (dentists, osteopaths, chiropractors, and podiatrists); TENN. CODE ANN. at §56-7-108 (1989) (optometrists, clinical psychologists, podiatrists, and social workers); *Id.* at §56-7-116 (chiropractors); *Id.* at §56-7-1002 (dentists); TEX. INS. CODE ANN. at §21.35A (Vernon 1989) (psychologists); *Id.* at §21.52 (Vernon 1989) (podiatrists, dentists, chiropractors, optometrists, audiologists, and speech-language pathologists); VA. CODE ANN. at §38.2-2203 (1986) (chiropractors); WASH. REV. CODE ANN. at §48.20.390 (1984) (podiatrists); *Id.* at §48.20.410 (optometrists); *Id.* at §48.20.411 (registered nurses); *Id.* at §48.20.412 (chiropractors); *Id.* at §48.20.414 (psychologists); *Id.* at §48.20.416 (dentists); W. VA. CODE at §33-6-30 (1988) (dentists, podiatrists, chiropractors, and optometrists); *Id.* at §33-16-3e (registered nurses and nurse midwives); WIS. STAT. ANN. at §628.33 (West 1980) (chiropractors); *Id.* at §632.87 (West Supp. 1989) (optometrists); WYO. STAT. at §26-22-101 (1983) ("person[s] licensed under laws of this state to treat the illness or disability or perform the health services"); *Id.* at §26-13-109 (dentists).

they would pay for the service if delivered by a medical physician. These laws go a long way toward opening up the health care market to at least some level of competition among providers. At the same time, they provide consumers with freedom to choose among licensed health care providers rather than requiring consumers to accept the uniform medical physician-dominated product the previously monopolized market would force upon them.

These Freedom of Choice laws regulate insurance. *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986). Because of the compelling State interest reflected in their passage, they should apply to self-funded benefit plans in even more compelling fashion than have anti-subrogation statutes or no-fault insurance plans. See *FMC Corp. v. Holliday*, 885 F.2d 79 (3rd Cir. 1989), cert. granted, \_\_\_ U.S. \_\_\_ (1990); *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), cert. denied, \_\_\_ U.S. \_\_\_, 108 S. Ct. 1754 (1988).

## II. The Deemer Clause Must Not Be Construed To Automatically Preempt Every State Insurance Law

### A. The Deemer Clause Must Be Viewed In Light Of Its Congressional History To Determine The Proper Scope Of The Clause

Although ordinarily the words of a statute are the best indication of Congressional intent, courts have long recognized that a statute, when read unqualifiedly, may apply to situations wholly unanticipated and unforeseen by Congress, leading to unreasonable results that Congress could never have intended.

It is a familiar rule that a thing may be within the letter of the statute and yet not within the statute, because not within its spirit nor within the intention of its makers. . . . [F]requently words of general



meaning are used in a statute, words broad enough to include an act in question, and yet a consideration of the whole legislation, or of the circumstances surrounding its enactment, or of the absurd results which follow from giving such broad meaning to the words, makes it unreasonable to believe that the legislator intended to include the particular act.

*Holy Trinity Church v. United States*, 143 U.S. 457, 459 (1892). In view of the expressed Congressional concern with the soundness and stability of benefit plans, it makes little sense that Congress meant to preempt state laws like Freedom of Choice laws that are directed at protecting consumers and at reducing health care costs through competition.

Nor does the legislative history of ERISA support a construction of the deemer clause that would preempt every state insurance law. It is undisputed that the language of ERISA's *preemption* clause, 29 U.S.C. §1144(a), together with its legislative history, demonstrate a Congressional intent to preempt all state laws "relating to" employee benefit plans. While the original versions of ERISA limited the scope of preemption to areas expressly covered by the bill, Congress expressly rejected that limited concept of preemption in favor of the present broad language of the preemption clause. It is equally clear from the language of the savings clause, 29 U.S.C. §1144(b)(2)(A), as well as its legislative history, that Congress meant to preserve the States' primacy in regulating insurance. Indeed, the Conference Committee Report stated "[t]he preemption provisions of Title I are not to exempt any person from any State law that regulates insurance." H. R. CONF. REP. NO. 93-1280, p. 383 (1974).

There is, however, no explanation in the legislative history of how the deemer clause was intended to relate to

the preemption clause and the savings clause, or of how much of the state-regulated field of insurance Congress intended to preempt. Determining the proper scope of the deemer clause is made more difficult by the fact that the first version of the deemer clause appeared in a House bill having a preemption clause of narrow scope. See H.R. 12906, SUBCOMM. ON LABOR OF THE HOUSE COMM. ON LABOR & PUBLIC WELFARE, 94TH CONG., 2D SESS., LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, at 2920-22. The Conference Committee that was convened to work out differences between the Senate and House versions of ERISA, broadened the preemption clause while retaining the savings and deemer clauses, but gave no comments concerning the relationship between the broadened preemption clause and the deemer clause. H.R. CONF. REP. NO. 93-1280 p. 383 (1974).

This Court has long recognized that where an area has been traditionally occupied by the States, the assumption is that the police powers of the States were not to be superseded unless that was the clear and manifest purpose of Congress. *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977). This assumption assures that the balance between federal and state powers will not be disturbed unintentionally by Congress or unnecessarily by the Courts. *Id.* In view of the lack of legislative comment regarding the proper scope of the deemer clause, it cannot be fairly said that Congress has demonstrated clearly and unequivocally that the application of *every* state insurance law to employee benefit plans was intended to be preempted.

**B. Congress Did Not Intend The Deemer Clause To Preempt Every State Insurance Law**

Although the language used by Congress in the deemer clause may appear to prevent the application of every state insurance law to every employee benefit plan, a closer review of the impact that such an interpretation would have on the health care market reveals that Congress could not have intended that result. Such absolute preemption of state insurance laws from applying to ERISA plans is not only inconsistent with Congressional intent to preserve state insurance laws, it in effect transfers to ERISA plan sponsors the power to legislate in areas unregulated by ERISA. Since ERISA does not regulate most substantive provisions of the plan contract, those plan provisions would become supreme law, requiring the automatic preemption of state law to resolve every conflict between the state law and the ERISA plan.

Certainly Congress could not have meant to defer its lawmaking authority to employers with self-funded ERISA plans, allowing them to adopt any plan provision they choose, so long as such plans comply generally with ERISA regulations. The potential for chaotic disruption of carefully crafted state regulatory schemes due to such absolute preemption is enormous. See *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, \_\_\_\_ U.S. \_\_\_\_, 108 S.Ct. 1754 (1988).

Moreover, state laws, such as Freedom of Choice laws, that are directed specifically at correcting problems in the health care industry will have a significantly reduced impact on the medical care market if they are precluded from applying to self-funded plans. These laws have been enacted to counter the rising costs of health care and to further the public interest in health, welfare and safety

by promoting competition among providers and freedom of choice of providers by consumers for otherwise covered services. These goals are promoted by prohibiting discrimination against legally recognized and licensed professionals.

It is inconceivable that Congress intended the deemer clause to be construed as creating a "bright-line" distinction between self-funded plans and insured plans without at least some discussion regarding the impact that total preemption would have on such critically important insurance laws. Self-funded plans are becoming the rule, not the exception. Without a clear mandate from Congress indicating otherwise, this Court should not construe the deemer clause to preempt state insurance laws that promote competition among health care providers, increase freedom of choice for consumers, and reduce health care costs not only for plan participants, but for the plans themselves. The more reasonable approach, as recognized by the Court of Appeals for the Third Circuit, is to balance the federal interest in uniform regulation for employee benefit plans against the States' strong interest in uniformly regulating certain aspects of the insurance industry, such as cost containment regulations, that also impact on self-insured plans.

### CONCLUSION

For the foregoing reasons, the American Chiropractic Association submits that the judgment of the Court of Appeals for the Third Circuit be affirmed.

Respectfully submitted,

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June 14, 1990



JUN 14 1990

JOSEPH F. SPANIOL, JR.  
CLERK

No. 89-1048

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IN THE  
SUPREME COURT OF THE UNITED STATES  
October Term, 1989

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FMC CORPORATION,

Petitioner,

v.

CYNTHIA ANN HOLLIDAY,

Respondent.

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ON WRIT OF CERTIORARI TO THE UNITED STATES  
COURT OF APPEALS FOR THE THIRD CIRCUIT

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BRIEF FOR THE PENNSYLVANIA TRIAL  
LAWYERS ASSOCIATION AS AMICUS CURIAE  
IN SUPPORT OF RESPONDENT

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STATEMENT OF THE INTEREST OF  
AMICUS CURIAE PENNSYLVANIA  
TRIAL LAWYERS ASSOCIATION

Pursuant to Rule 37.2 of the Rules of the Supreme Court of the United States, the Pennsylvania Trial Lawyers Association files this Brief as Amicus Curiae supporting the position of Respondent Cynthia Ann Holliday. Signed consents permitting the filing of this Brief, from Counsel for Petitioner FMC Corporation Charles Kelly, and from Attorney Thomas G. Johnson representing Respondent Cynthia Ann Holliday, have been filed with the Clerk of this Honorable Court. The Pennsylvania Trial Lawyers Association is a private non-profit association with a membership of nearly 4,500 trial attorneys in the Commonwealth of Pennsylvania, predominately representing injured

parties in their attempt to seek redress for their injuries in the Courts. The issue of subrogation in Pennsylvania automobile cases has a significant impact on the interests of injured parties and on the practice of law in Pennsylvania. Any determination, therefore, by this Honorable Court of the issues in the case at bar will directly affect the members of the Pennsylvania Trial Lawyers Association and the interests of their clients.

This Brief is filed timely pursuant to the schedule established by Order of this Honorable Court for the filing of the Brief of the Respondent.

### SUMMARY OF ARGUMENT

This Court has repeatedly stated that it is necessary to consider the Congressional purpose behind the ERISA preemption, savings and deemer clauses in order to determine if a state law is preempted by ERISA. There is a presumption against preemption and this Court has determined that Congress did not intend that the ERISA preemption clause would invade the traditional areas of state regulation, including motor vehicle insurance laws which includes the Pennsylvania Motor Vehicle Financial Responsibility Law.

The "bright line" test of Metropolitan Life Insurance Co., does not provide an easy answer to the facts of this case. FMC itself has invoked

the Pennsylvania law in question and has used and seeks to continue to use parts of the state law to its own advantage. It therefore asks that this Court only preempt certain portions of the Pennsylvania law although this Court has previously stated that a law that is preempted by ERISA is not saved merely because it furthers the purpose of a plan or the substantive requirements of the ERISA statute. Therefore, FMC cannot preempt only those portions of the law it seeks to ignore. Any administrative burden caused by different motor vehicle insurance laws in each state was willingly assumed by FMC when it specifically incorporated those different laws into its plan. If this Court were to reverse the decision

below, it would not promote national uniformity in the administration of this ERISA plan since the plan itself sought to invoke the benefits of the different statute in each state.

The Pennsylvania law comes within the definition of the "savings clause" and it does not "deem" the plan to be an insurance company. The law in question regulates insurance companies as well as other entities and the Court below found that the plan was covered by Section 1719 of the Pennsylvania law, which section applies to insurance companies as well as to other noninsurance entities. Therefore, the Pennsylvania law does not run afoul of the deemer clause of ERISA.



6  
ARGUMENT

I. CONGRESS DID NOT INTEND AND THE DECISIONS OF THIS COURT DO NOT REQUIRE THAT THE PENNSYLVANIA MOTOR VEHICLE FINANCIAL RESPONSIBILITY LAW BE PREEMPTED BY SECTION 514 OF ERISA.

All of the parties and virtually all of the Amicus briefs agree that three sections of the Employment Retirement Income Security Act of 1984 (ERISA), 29 U.S.C. §1144, must be analyzed to determine if the Pennsylvania Motor Vehicle Financial Responsibility Law (MVFRL) is preempted in this case.

Section 514(a) of ERISA, 29 U.S.C. §1144(a), provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan". Therefore the first test of preemption is whether a state law comes within the

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meaning of section 514(a) such that it would be preempted.

If a state law comes within this section, then one must determine if it comes within the "savings clause" which provides as follows:

Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

29 U.S.C. §1144(b)(2)(A). All of the parties and their amicus supporters agree that the MVFRL is "saved" by the savings clause.

When a particular state law is "saved" by this section, then we must still look to the so-called "deemer clause" which provides as follows:

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other

insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies or investment companies.

29-U.S.C. §1144(b)(2)(B).

It might initially seem that one could simply read these three sections and reach a determination as to whether or not the MVFRL is preempted by ERISA. However, the path to such a decision is not that clear. This Court has noted that:

The two preemption sections, while clear enough on their faces, perhaps are not a model of legislative drafting, for while the general pre-emption clause broadly preempts state law, the savings clause appears broadly to preserve the States' lawmaking power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously

taken away, it does not normally do both at the same time.

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 2389, 85 L.Ed.2d 728 (1985).

The FMC Corporation and its Amicus supporters would argue that the Court can simply apply the "bright line" test of Metropolitan Life to determine whether or not a particular law is preempted. The test would solely turn on whether a plan was self-funded or purchased insurance policies to provide benefits. Apparently, FMC argues that a self-funded plan is not subject to any state laws of any type no matter how tenuous the relationship is to a plan. This method of analysis is

appropriate and useful in determining whether ERISA preempts state laws that require insurance companies or other entities to provide certain mandatory minimum benefits. However, the test is too simplistic and inappropriate to apply in a case such as the matter at bar which does not involve the mandatory provision of benefits. The Court of Appeals below has applied this bright line test in appropriate cases, see Insurance Board of Bethlehem Steel Corp. v. Muir, 819 F.2d 408, 410 (3d Cir. 1987). However, the Court of Appeals held that this test was inappropriate to determine the issues in the case at bar.

Contrary to the argument of FMC and its supporters, this Court has held that it is necessary to determine the

intention of the Congress in enacting the preemption clause in order to determine if a particular law is preempted by ERISA. Shaw v. Delta Airlines, Inc., 463 U.S. 85, 95, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983); Metropolitan Life Ins. Co., 105 S.Ct. at 2389; Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 51-52, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). There is a presumption against preemption. Metropolitan Life Ins. Co., 105 S.Ct. at 2390.

While the preemption clause of ERISA is very broad, this Court has determined that "we must also presume that Congress did not intend to preempt areas of traditional state regulation." Metropolitan Life Ins. Co., 105 S.Ct. at 2389. Certainly state automobile



insurance laws are a familiar example of an area of traditional state regulation; see Metropolitan Life Ins. Co., 105 S.Ct. at 2383.

The Congressional intent in enacting the preemption provision of ERISA was to shield benefit plans from conflicting state and local regulations which would interfere with the administration of employee benefit plans. Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 107 S.Ct. 2211, 2216-2217, 96 L.Ed.2d 1 (1987); Shaw, 463 U.S. at 105. Congress intended for ERISA to do this without interfering with the ability of the states to regulate their traditional areas of responsibility.

ERISA pre-emption analysis 'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.'

Fort Halifax Packing Co., 107 S.Ct. at 2221, citing Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 522, 101 S.Ct. 1895, 1905 (1981). This is exactly the analysis which the Court of Appeals undertook in this matter. This analysis was in keeping with the clear mandate of the decisions of this Court.

State automobile insurance laws are clearly a traditional area of regulation by the states and all of the briefs submitted in this matter agree that the MVFRL is such a state automobile insurance plan. Nonetheless, Petitioner and its amicus supporters do not undertake any analysis as to the Congressional intent behind the preemption clause other than to argue that it is an automatic preemption which requires no further analysis.

This argument does not comport with the decisions of this Court noted above.

This Court has in several of its recent decisions permitted state laws to withstand preemption even beyond those that would be saved by the "savings clause" of ERISA. Mackey v. Lanier Collections Agency, 486 U.S. 825, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988); Fort Halifax Packing Co., Inc. v. Coyne, supra.

In Mackey v. Lanier Collections Agency, the Supreme Court considered a Georgia garnishment law which specifically exempted the funds or benefits of an ERISA employee benefit plan from garnishment. The Court initially struck that portion of the Georgia garnishment law because it

specifically applied only to ERISA plans. However, the Court refused to rule that ERISA superseded Georgia garnishment laws in general and as part of its discussion listed numerous state laws which "although obviously affecting and involving ERISA plans and their trustees, are not preempted by ERISA §514(a)." 108 S.Ct. at 2187. The Court in Mackey analyzed the purpose behind the preemption clause and held that Congress did not intend to preempt garnishment laws even though they do "relate to" ERISA benefit plans.

A similar result was reached in Rebaldo v. Cuomo, 749 F.2d 133 (2d Cir. 1984). There the Second Circuit held that the state plan regulating hospital insurance rates was not preempted by

ERISA noting that it is clear that ERISA does not preempt every state law that incidentally touches pension plans. 749 F.2d at 138. In Shaw v. Delta Airlines, Inc., 463 U.S. 85, 87, 103 S.Ct. 2890, 2901 the Supreme Court held that "some state actions may effect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."

The Pennsylvania MVFRL is not directed at ERISA plans nor does it deal with the subjects regulated by ERISA. This Pennsylvania law is concerned with no-fault automobile insurance and state civil pleading and evidentiary rules, all of which are areas of traditional state regulation. It does not require employee benefit

plans to provide coverage for automobile accidents or even to provide any health benefits coverage at all. The MVFRL does not materially "relate to" or "purport to regulate" ERISA plans and therefore is not preempted. Indeed, it is the FMC Corporation itself which invoked the Pennsylvania MVFRL for its benefit and now seeks to preempt only certain portions of that law.

## II. ERISA DOES NOT PERMIT A PARTIAL PREEMPTION OF A STATE LAW AS PETITIONER REQUESTS.

It must be noted that the FMC plan specifically invokes state automobile no-fault motor vehicle coverage. In this case FMC took advantage of the Pennsylvania MVFRL to its benefit. As the Amicus brief for the United States notes in footnote 1 on page three of



its brief, the Plan took advantage of the statute to have the first \$10,000.00 of medical expenses paid by Mr. Holliday's automobile insurance carrier. It also appears, as noted in that footnote, that the plan obtained further relief from the Pennsylvania Catastrophic Loss Trust Fund established in the Pennsylvania MVFRL, 75 Pa. C.S.A. §§1761 et seq. (Repealed December 12, 1988). The Catastrophic Loss Trust Fund was a state established medical fund financed by a charge on every registered vehicle in the state which paid those medical expenses incurred in motor vehicle accidents in excess of \$100,000.00.

FMC does not actually seek to preempt the entire state law but rather seeks to preempt Section 1720 of the

law while taking advantage of all of the other benefits of the law. This Court has already decided that if a state law is preempted then it does not matter that the state law is consistent with the purposes of the benefit plan or with the substantive requirements of ERISA. Mackey, 108 S.Ct. at 2185; Metropolitan Life, 105 S.Ct. at 2389. As this Court pointed out in Mackey,

. . . there is simply no logical way to construe the English language so that garnishment or attachment laws "relate to" benefit plans when they are invoked by creditors of the beneficiaries, but not when they are invoked by beneficiaries or creditors of the plan itself.

Mackey, 108 S.Ct. at 2188.

In Mackey, the Georgia garnishment law in question clearly supported the benefit plan and furthered the purpose

of ERISA by exempting funds or benefits of a plan from garnishment. This Court held that this portion of the Georgia garnishment law was preempted. FMC has not attempted to explain how parts of the MVFRL would be preempted but other parts would not.

In its brief before the Third Circuit Court of Appeals, FMC stated that it wanted to invoke Pennsylvania state law on subrogation and cited several Pennsylvania case decisions to that effect. (FMC did this even though subrogation has not been available in automobile cases in Pennsylvania since the passage of the 1974 No-Fault Motor Vehicle Insurance Act.) If state laws "relate to" ERISA plans when they prohibit subrogation, then the state laws permitting subrogation in other

cases would also <sup>21</sup>"relate to" ERISA plans. These subrogation laws would also be preempted and therefore not available to FMC. FMC tried to skirt this issue by referring to the subrogation law as "common law" but its citation of Pennsylvania cases clearly indicated that it was referring to Pennsylvania common law. "Common law" is judicial decisional law as opposed to statutory law. Under the definition section of ERISA:

The term "state law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.

29 U.S.C.S. §1144(c)(1). Obviously this would include judicially decided common law. If all state laws are automatically superceded even if they only remotely relate to an ERISA plan,

as FMC argues, then FMC could not take advantage of state subrogation laws as it seeks to do in this case. As this Court determined in Mackey, Congress never intended to provide such an unbounded preemption.

The mischief posed by FMC's interpretation of ERISA preemption would go even beyond this point. As the Petitioner quotes its plan on page 5 of its brief the plan requires that:

If you bring a liability claim against any third party, benefits payable under this Plan must be included in the claim, and when the claim is settled you must reimburse the Plan for the benefits provided.

Under the MVFRL and similar state automobile insurance laws, injured parties are often precluded from pleading or proving certain items of

damages in tort actions or are otherwise restricted in bringing a suit in tort. FMC's argument, however, is that its subrogation language in the benefit plan would be enforced regardless of state law. This would mean either that injured parties would have to pay monies to FMC that they did not recover in state court actions, a definition of "subrogation" not known heretofore, see Allstate Insurance Co. v. Clarke, 364 Pa. Super. 196, 527 A.2d 1021 (1987), or else FMC would have the federal courts change state automobile tort law. Indeed, a plan could write any procedural or evidentiary rule into its plan and seek to enforce it against non-beneficiaries. The state laws limiting evidence or items of damages in a no-fault system would be preempted



under FMC's argument. For example, in the case at bar, Ms. Holliday would be required to bring FMC's claim against the Defendant tortfeasor even though a state law may prohibit the pleading or proof of certain elements of medical damages. Such a position would mean chaos in the legal system. Because a self-funded ERISA plan put certain provisions into its Plan, a plan beneficiary could sue a defendant for damages not permitted to a non-beneficiary in the same accident. This would not be a case of federal law preempting state law but, rather, a case of a private plan preempting state law. Such a result could never have been the intention of Congress. This would require a severe intrusion upon a traditional area of state regulation

while the state law only incidentally touches an ERISA plan.

III. REVERSAL IN THE CASE AT BAR WILL NOT PROMOTE UNIFORMITY IN THE ADMINISTRATION OF ERISA PLANS.

The major argument advanced by Petitioner and its amicus supporters is that reversal of the Court below will somehow enhance uniformity of the administration of ERISA plans. This is clearly not the case. It cannot be overlooked that it was the Petitioner FMC Corporation which invoked the Pennsylvania MVFRL by the language in its plan. The FMC plan invokes the state automobile insurance law of each state in coordinating and construing its benefits. By doing so, the plan obviously intends to save money but immediately subjects itself to

different state insurance schemes in each of the 50 states. The fact that FMC itself would invoke such laws clearly undercuts its argument that uniformity is necessary as to its subrogation interest when it is the plan itself that invoked 50 separate schemes. If uniformity of administration had such overriding importance as FMC argues to this Court, it is hard to understand why the FMC plan would deliberately chose to invoke 50 different laws.

IV. SECTION 1720 OF THE MVFRL DOES NOT "DEEM" THE FMC BENEFIT PLAN TO BE IN THE BUSINESS OF INSURANCE.

All of the parties and their amicus supporters agree that if the MVFRL "relates to" ERISA such that it is superseded by §514(a), then it is "saved" by §514(b)(2)(A).

This means that the MVFRL would not be preempted by ERISA unless the Pennsylvania law "deems" the benefit plan to be an insurance company or other insurer for purposes of any law purporting to regulate insurance companies or insurance contracts. 29 U.S.C. §1144(b)(2)(B). It is important to note that the language of the savings clause and the language of the deemer clause are different. The savings clause is very broadly worded to preserve all state laws regulating insurance. The deemer clause will only allow preemption in the specific instances where the state law "deems" the benefit plan to be an insurance company or other insurer as specified in the deemer clause.

An analysis of the plain language of the MVFRL shows that it does not "deem" the benefit plan to be an insurer in refusing to recognize subrogation. The language in Sections 1719 and 1720 of the MVFRL differentiates between insurance companies and other entities that might provide benefits as listed in that law. FMC recognizes this and in its brief in the Court below pointed out that Section 1720 precludes recovery for four types of entities, each entity defined separately in Sections 1711, 1712, 1715 and 1719 of the MVFRL. FMC recognized that Sections 1711, 1712 and 1715 apply distinctly and solely to insurance companies. If Cynthia Holliday had attempted to resist the subrogation clause pursuant to any of those three

sections, then the MVFRL would effectively be deeming the benefit plan to be an insurance company or other insurer. This would not be permitted under ERISA.

In the case at bar, however, the Court below found that Section 1719 of the MVFRL applied to the Petitioner. This particular section of the MVFRL applies to insurance companies as well as to other entities, although "its principal and substantial effect is nonetheless on the insurance industry". FMC v. Holliday, 885 F.2d 79, 86 (3d Cir. 1989). Therefore, it was not necessary for the MVFRL to deem the benefit plan to be an insurance company or other insurer and the Statute does



not run afoul of the "deemer clause".<sup>30</sup>1

FMC has argued that several decisions of the Courts of Appeals for

1. It may be argued that, because the MVFRL to this extent also applies to entities other than solely insurance companies, it may be outside the savings clause. However such is not the case. In United Food & Commerical Workers v. Pacyga, 801 F.2d 1157 (9th Cir. 1986), a case cited with approval by FMC Corporation to this Court, the Court of Appeals for the Ninth Circuit noted that the anti-subrogation law in that case applied to parties other than insurance companies but held nonetheless that the law substantially complied with the test of a McCarran-Ferguson Law and therefore came within the savings clause. 801 F.2d at 1161. Both this Court and the Supreme Court have recognized that no one part of the three part McCarran- Ferguson test is dispositive and a law may regulate the insurance business without fully complying with all three requirements. Pilot Life, 41 U.S. at 51; Insurance Board of Bethlehem Steel Corp. v. Muir, 819 F.2d 408, 411 (3d Cir. 1987); FMC v. Holliday, 885 F.2d 79, 86 (3d Cir. 1989); Northern Group Services v. Auto Owners Insurance Co., 833 F.2d 85, 90 (6th Cir. 1987).

the various Circuits have found a different interpretation of the deemer clause than argued herein. However, the cases cited by the Petitioner are readily distinguished from the issue in the case at bar. In Childrens Hospital v. Whitcomb, 778 F.2d 239 (5th Cir. 1985), the Court preempted a state statute mandating that benefit plans provide a certain level of benefits for mental health problems and other illnesses. In Liberty Mutual Insurance Group v. Iron Workers Health Fund of Eastern Michigan, 879 F.2d 1384 (6th Cir. 1989), the Court preempted a state law that required benefit plans to pay benefits to automobile accident victims. These decisions are directly controlled by this Court's decision in Metropolitan Life and the state law in

each case would necessarily treat the plan as an insurance company.

In Powell v. Chesapeake & Potomac Telephone Co. of Virginia, 780 F.2d 419 (4th Cir. 1985), cert. denied, 476 U.S. 1170 (1986), the issue was whether the state insurance trade practices law applied to a benefit plan. To hold the plan subject to the insurance trade practices law would necessarily require that the state "deem" the plan to be an insurance company. In United Food & Commerical Workers v. Pacyga, 801 F.2d 1157 (9th Cir. 1986) and Baxter v. Lynn, 886 F.2d 182 (8th Cir. 1989), the Circuit Courts preempted state laws prohibiting subrogation in general. Neither of these cases involved a comprehensive state automobile insurance law regulating this

traditional area of state interest. Indeed, the Baxter decision determined that since this was a question of the state common law prohibition on subrogation, the subrogation law was not directed toward the insurance industry and therefore did not even come within the "savings clause" of ERISA. There is agreement among all of the parties and the amicus supporters that the MVFRL does come within the savings clause. In Pacyga, the Ninth Circuit gave very limited discussion to whether the general subrogation statute was directed at the insurance industry and noted that it did simply because "many of the Arizona cases relating to the law" were insurance cases although the Court noted that many cases were not. That case did not involve a

comprehensive state automobile insurance law as does the case at bar. The only cases which analyzed ERISA preemption and the traditional state regulation area of motor vehicle insurance laws were the case at bar and Northern Group Services v. Auto Owners Insurance Co., 833 F.2d 85 (6th Cir. 1987). Both of these decisions found it necessary to analyze the reasons behind the preemption, savings and deemer clauses and determined that the state motor vehicle insurance law was not preempted by ERISA.

A straightforward reading of the deemer clause in conjunction with the savings clause will show that the MVFRL does not "deem" the plan to be an insurance company or other insurer and therefore, given the agreement by all

parties that the MVFRL is covered by the savings clause so as to avoid preemption, the Pennsylvania Law is not preempted.

### CONCLUSION

The congressional purpose behind the ERISA preemption, savings and deemer clauses does not support preemption of Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law. FMC is not permitted to pick those portions of state laws which it wants to preempt and those portions of state laws which it wishes to exercise for its own benefit. The FMC Corporation specifically incorporated 50 different state automobile insurance laws into



its plan and reversing the Court below will therefore not further national uniformity in the administration of this ERISA plan.

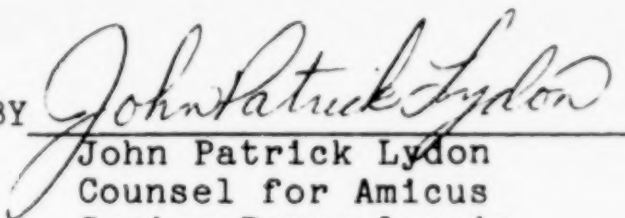
There is no simple test for determining the congressional intent behind the preemption clause given the facts in this case. There is a presumption against preemption. Given the tremendous mischief that the FMC position would wreak on state tort systems as well as on state comprehensive automobile insurance plans, there is no reason for ERISA to preempt this state law.

The congressional purpose behind the preemption clause of ERISA would best be served by affirming the

judgment of the Court of Appeals for the Third Circuit.

Respectfully submitted,

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**Supreme Court of the United States**

**October Term, 1989**

**FED. CORPORATION,**

*Petitioner,*

**v.**

**CYNTHIA ANN HOLLIDAY,**

*Respondent.*

**On Writ of Certiorari to the United States  
Court of Appeals for the Third Circuit**

**BRIEF OF THE  
NATIONAL CONFERENCE OF STATE LEGISLATURES,  
NATIONAL LEAGUE OF CITIES,  
NATIONAL GOVERNORS' ASSOCIATION,  
NATIONAL ASSOCIATION OF COUNTIES,  
COUNCIL OF STATE GOVERNMENTS,  
INTERNATIONAL CITY MANAGEMENT ASSOCIATION,  
AND U.S. CONFERENCE OF MAYORS  
AS AMICI CURIAE IN SUPPORT OF RESPONDENT**

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### **QUESTION PRESENTED**

Whether the so-called "deemer clause" of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(b)(2)(B), preempts a state anti-subrogation provision as it applies to a self-insured employee welfare benefit plan.



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IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1989

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No. 89-1048

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FMC CORPORATION,  
v. *Petitioner,*

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*Respondent.*

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On Writ of Certiorari to the United States  
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**BRIEF OF THE  
NATIONAL CONFERENCE OF STATE LEGISLATURES,  
NATIONAL LEAGUE OF CITIES,  
NATIONAL GOVERNORS' ASSOCIATION,  
NATIONAL ASSOCIATION OF COUNTIES,  
COUNCIL OF STATE GOVERNMENTS,  
INTERNATIONAL CITY MANAGEMENT ASSOCIATION,  
AND U.S. CONFERENCE OF MAYORS  
AS AMICI CURIAE IN SUPPORT OF RESPONDENT**

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**INTEREST OF THE AMICI CURIAE**

*Amici* are organizations whose members include state, county, and municipal governments and officials throughout the United States; they have a compelling interest in legal issues that affect state and local governments.

This case concerns petitioner's contention that the so-called "deemer clause" of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(b)(2)(B), preempts all state insurance laws as they relate to self-insured employee welfare benefit plans. This contention has enormous importance for the States. If accepted, it would oust the States of a large portion of their au-

thority to regulate insurance, a subject that long has been recognized by Congress and this Court as an area within the States' traditional purview. It also would create wholly irrational distinctions between employees, some of whom (those whose employers offer fully insured plans) would continue to receive the protections of state insurance law, and some of whom (those whose employers self-insure) would lose those protections. *Amici* therefore submit this brief to assist the Court in the resolution of this case.<sup>1</sup>

### INTRODUCTION AND SUMMARY OF ARGUMENT

1. This case turns on the preemptive reach of ERISA's so-called "deemer clause," an opaque provision, added to the statute without explanation, that precludes a State from "deem[ing]" an employee benefit plan to be an insurance company (or from "deem[ing]" the plan to be engaged in the business of insurance) for purposes of state laws regulating insurance companies or contracts. 29 U.S.C. § 1144(b)(2)(B). Petitioner and the Solicitor General read the clause as though it provided that all state laws regulating insurance are preempted insofar as they relate to self-insured—but not to fully insured—plans. This reading, however, has no relationship to the actual language of the statute. The deemer clause does not, after all, make any distinction between self-insured and fully insured plans, and it does not, in terms, provide that *all* state insurance laws are superseded as to *all* plans.

In fact, Congress meant exactly what it said in the deemer clause: it wrote the provision to preclude States from "deem[ing]" plans to be insurance companies for purposes of state laws, such as those involving licensing or capitalization, that apply to insurance *as a business*. It is apparent that the clause was drafted in response to the concern, widely discussed at the time of ERISA's enactment, that the States inevitably would drive self-

<sup>1</sup> Both parties' letters of consent pursuant to Rule 37 of the Rules of this Court have been filed with the Clerk of the Court.

insured plans out of existence if they subjected those plans to the licensing, reserve, premium, and filing requirements that state laws impose on insurance companies. Indeed, this concern was given special urgency by a state court judgment, pending on appeal at the time the deemer clause was written, that required a self-insured plan to obtain an operating license from state insurance authorities. In our view, the clause was Congress's response to the problem.

At the same time, Congress did not mean to set aside those aspects of state health and insurance policy that relate to the substance of insurance coverage. This explains the difference in language between the saving and deemer clauses: the former saves any state law regulating "insurance," while the latter is directed at insurance companies and "the business of insurance."

2. Our reading of the deemer clause is consistent with other elements of ERISA, which nowhere distinguishes between self-insured and fully insured plans. And our analysis is wholly faithful to the legislative history. The deemer clause was inserted in ERISA at a time when the preemption clause, which sets the outer limits of preemption, was written in a way that would have superseded only state laws dealing with matters specifically covered by ERISA (such as reporting requirements and fiduciary obligations); at its broadest, the language of the deemer clause accordingly could have been intended to preempt only state laws addressing those areas. In fact, the only specific evidence of the intended application of the ERISA preemption provisions indicates that they were modeled on a statute preempting state laws relating to the creation, management, and structure of health maintenance organizations. The deemer clause was designed to reach the same sorts of laws as they apply to welfare benefit plans.

3. Our reading of the deemer clause also is compelled by the policies that underlie ERISA. Because federal law does not regulate the substance of welfare benefit plans,

petitioner's reading of the clause would (unless the federal courts stepped in to create a federal common law of insurance) leave an enormous regulatory vacuum. That outcome would afford employees less protection than they enjoyed before the enactment of ERISA. Moreover, from the standpoint of plan participants—the people who are the intended beneficiaries of the statute—it is irrelevant whether a plan is self-insured or fully insured; petitioner would distinguish on this wholly irrational basis in determining which employees benefit from the protections of state health insurance law. Against this, petitioner and the Solicitor General argue only that self-insured plans would find it inconvenient to comply with varying state laws. ERISA, however, was enacted not to protect plans, but to “‘promote the interests of employees and their beneficiaries.’” *Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948, 955 (1989) (citation omitted).

Similar problems inhere in petitioner's contention that the decision below will encourage litigation. In fact, given the regulatory vacuum that would follow from preemption here, the federal courts would have no choice but to create a federal common law of insurance. Yet such a development would engender enormous confusion. Plans would be forced to engage in continuous litigation if their obligations were set by an inchoate body of federal common law that was discovered by the courts on a case-by-case basis. The federal courts, meanwhile, would have to invent rules in an area that has been the traditional province of the States. This Court, moreover, would have no choice but to step in repeatedly to set the contours of the new common law. Such a system, it seems to us, is earnestly to be avoided.

## ARGUMENT

### I. SECTION 514 OF ERISA DOES NOT PREEMPT PENNSYLVANIA'S ANTI-SUBROGATION LAW.

#### A. Petitioner's Reading Of The Deemer Clause Cannot Be Reconciled With The Statutory Language.

1. The structure of ERISA's complex preemption provision has become familiar. “If a state law ‘relate[s] to . . . employee benefit plan[s],’ it is pre-empted. § 514(a). The saving clause excepts from the pre-emption clause laws that ‘regulat[e] insurance.’ § 514(b)(2)(A). The deemer clause makes clear that a state law that ‘purport[s] to regulate insurance’ cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B).” *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 45 (1987). Although a convincing argument may be made to the contrary, we assume for purposes of our discussion below that Section 1720 of Pennsylvania's Motor Vehicle Financial Responsibility Law, 75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1989), as applied to petitioner, “relate[s] to an employee benefit plan” and therefore is within the scope of the preemption clause.<sup>2</sup> The parties and the So-

<sup>2</sup> The arguments to the court of appeals were largely directed at the meaning of the deemer clause; we accordingly devote most of our attention to that issue. But those arguments skipped too easily past the preemption clause, for in our view Section 1720 does not “relate to” an ERISA plan within the meaning of that provision. Because the court below considered and addressed this issue at some length (see Pet. App. A13-A15) in response to an *amicus* argument that was expressly endorsed by respondent (see Appellee C.A. Br. 17 n.2), it would be appropriate for this Court to consider the issue as well.

The Court has several times indicated, of course, that “[a] law ‘relates to’ an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.” *Mackey v. Lanier Collection Agency*, 486 U.S. 825, 829 (1988), quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983) (emphasis omitted). See *Pilot Life*, 481 U.S. at 47-48; *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). At the same time, however, the Court has made clear that many state laws—even some that have a direct impact and impose affirmative obligations on plans—do not fall within the scope of the



licitor General agree that the Pennsylvania law also falls within the insurance saving clause. Pet. Br. 11; U.S. Br. 11. The dispositive question here, then, is whether Pennsylvania's statute is preempted by the deemer clause.

In arguing for preemption, petitioner and the Solicitor General read the deemer clause as though it provides that, notwithstanding the saving clause, all state laws involving insurance are preempted insofar as they relate to self-insured—but not to fully insured<sup>3</sup>—welfare benefit plans.

preemption clause. See *Mackey*, 486 U.S. at 833. Cf. *Shaw*, 463 U.S. at 100 n.21. Indeed, the Solicitor General has conceded in the past that general state tort and contract law may be applied against plans (see *Mackey*, 486 U.S. at 833), and the Court has observed that suits grounded on such laws “are relatively commonplace.” *Ibid.* (footnote omitted). See *Rebaldo v. Cuomo*, 749 F.2d 133, 138-139 (2d Cir. 1984).

Relying both on this observation and on ERISA's sue-and-be-sued provision—a type of clause generally understood to authorize “‘all civil process[es] incident to . . . legal proceedings’” (*Mackey*, 486 U.S. at 834 n.9 (citation omitted))—the Court has held that general state garnishment rules are not preempted as applied to plans. See *id.* at 841. By the same token, it is plain that normal procedural and claim allocation rules, such as those governing impleader and interpleader, must be applicable to plans in ordinary tort and contract suits. In this light, there can be little doubt that a State's usual subrogation rules, as an element of state tort law that allocates entitlements to tort judgments, should be fully applicable to ERISA plans. If Section 1720 “relates to” a plan, then, it must be because the state law creates a special subrogation rule for the allocation of tort judgments in the setting of liability for automobile accidents. But it is difficult to see why that factor should be dispositive. If subrogation rules do not “relate to” plans when applied to one type of tort judgment, there is, as the Court noted in a very similar setting, “‘simply no logical way to construe the English language’” that would make such laws “relate to” plans when applied to another type of tort judgment. *Mackey*, 486 U.S. at 830 (citation omitted).

<sup>3</sup> We use the term “self-insured” to refer to plans that pay benefits out of their own assets; we use the term “fully insured” to refer to plans that purchase coverage for employees from commercial insurance carriers. As we explain below, however, many self-insured plans actually are hybrids, purchasing coverage to protect themselves against excess liability. See page 23, *infra*.

This reading, however, has no relationship to the actual language of the statute. The deemer clause does not, after all, make any distinction between self-insured and fully insured plans, and it does not, in terms, provide that *all* state insurance laws are superseded as to *all* plans. Instead, the clause uses a different and rather curious formulation, providing, as paraphrased by the Court, that a State “cannot deem an employee benefit plan to be an insurance company.” *Pilot Life*, 481 U.S. at 45.

Any proper reading of the deemer clause must account for its unusual phrasing. In fact, in our view Congress meant exactly what it said in the deemer clause: as we explain more fully below, it wrote the clause to preclude States from “deem[ing]” plans to be insurance companies for purposes of state laws, such as those involving licensing or capitalization, that apply to insurance *as a business*. At the same time, Congress did not mean to set aside those aspects of state insurance and health policy that relate to the substance of insurance coverage. This reading of the clause, in contrast to petitioner's, has the paramount virtue of “‘begin[ning] with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose.’” *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 740 (1985) (citation omitted). Unless there is a compelling reason to depart from it, that language should be the end of the analysis as well.

2. There is no such reason here. To the contrary, our approach, unlike petitioner's, is consistent not only with the terms of the deemer clause, but also with the structure of other elements of ERISA. Petitioner and the Solicitor General acknowledge that their reading distinguishes between self-insured and fully insured plans by allowing for indirect state regulation of the latter; they recognize that, under this Court's holding in *Metropolitan Life*, States may mandate the benefits offered by fully insured plans through regulation of the insurance companies from which the plans purchase their coverage.

ERISA, however, expressly rejects any distinction either between the two types of plans or between direct and indirect state regulation. To the contrary, the preemption provisions define "State" to include any entity "which purports to regulate, *directly or indirectly*, the terms and conditions of employee benefit plans." Section 514(c)(2), 29 U.S.C. § 1144(c)(2) (emphasis added). Thus, the "directness" of the regulation should not determine preemption (as it does under petitioner's approach); the inquiry should turn on identifying the range of substantive areas preempted by ERISA. And far from distinguishing between self-insured and fully insured plans, the statute simply defines an "employee welfare benefit plan" as any program that provides medical or similar benefits "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). The term "plan" is then used throughout ERISA, as it is in the deemer clause, without distinction between plans that purchase insurance and those that self-insure.<sup>4</sup>

<sup>4</sup> The statute distinguishes between self-insured and fully insured plans at only one point, in an amendment to Section 514 enacted in 1983. 29 U.S.C. § 1144(b)(6). It is instructive to note that the amendment provides (with some exceptions) that multiple employer welfare benefit plans that are *not* fully insured are subject to all state laws regulating insurance (29 U.S.C. § 1144(b)(6)(A)(ii)); such plans that *are* fully insured (or which receive an exemption from the Secretary of Labor) are subject only to state insurance laws regulating reserve and contribution levels. 29 U.S.C. § 1144(b)(6)(A)(i). (The amendment was written to stop abuse of so-called multiple employer health trusts, which sold insurance coverage to many employers but attempted to avoid state regulation as insurance companies by claiming to be ERISA plans. See 128 Cong. Rec. 30,356-30,358 (remarks of Rep. Erlenborn) (1982)). This distinction sensibly allows for *greater* state regulation of self-insured plans that rely on their own resources to meet their obligations to participants, and lesser regulation of fully insured plans that have provided for participants by contracting with established insurance carriers. See 29 U.S.C. § 1144(b)(6)(D). Petitioner would turn this distinction on its head by postulating that participants in self-insured plans need *no* state protections.

## B. ERISA's Legislative History Confirms That The Deemer Clause Preempts Only State Laws Directed At The Business Aspects of Insurance.

Our reading of the deemer clause does more than track the statutory language; it also accords with the statute's legislative history, with the underlying purposes of the preemption provisions, and with the overall objectives of ERISA. See generally *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 8-9 (1987). And it indulges the presumption—fully applicable in ERISA litigation but ignored by petitioner and the Solicitor General—"that Congress did not intend to pre-empt areas of traditional state concern." *Metropolitan Life*, 471 U.S. at 740. See *id.* at 741; *Massachusetts v. Morash*, 109 S.Ct. 1668, 1675 (1989); *Fort Halifax*, 482 U.S. at 19; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981).

1. The three relevant preemption provisions have a complex history. The insurance saving clause was present in its current form in every one of the pension reform bills that led to the enactment of ERISA, dating back to 1970. See *Metropolitan Life*, 471 U.S. at 745 n.23. But neither the existing preemption clause nor any version of the deemer clause was present in the ERISA bills that initially were introduced in either Chamber of Congress.

As introduced in the Senate and reported out of the Committee on Labor and Public Welfare, the bill that ultimately became ERISA contained a limited preemption clause that would have superseded state laws only "insofar as they \* \* \* relate to the subject matters regulated by this Act." S.4, 93d Cong., 1st Sess. § 609(a) (1973), reprinted at 1 Staff of Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare, 94th Cong., 2d Sess., *Legislative History of the Employee Retirement Income Security Act of 1974*, 93, 186 (Comm. Print 1976) [hereinafter *Leg. Hist.*]. See also S. 1557, 93d Cong., 1st Sess. § 18(a) (Finance Committee bill) (1973), reprinted at 1 *Leg. Hist.* 280, 319. As noted above, the bill contained the insurance saving clause in its present form;



it did not contain the deemer clause. See S. 4, *supra*, reprinted at 1 *Leg. Hist.* at 186. See generally S. Rep. No. 127, 93d Cong., 1st Sess. 35 (1973), reprinted at 1 *Leg. Hist.* 587, 621. The Senate approved the bill in this form. See 3 *Leg. Hist.* 3820.

As introduced in the House, the bill that became ERISA contained a more precise but equally limited preemption clause: it would have superseded state laws relating "to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans." H.R. 2, 93d Cong., 1st Sess. § 114 (1973), reprinted at 1 *Leg. Hist.* 3, 50-51. The bill was approved by the Committee on Education and Labor in a slightly modified form. H.R. 2, 93d Cong., 1st Sess. § 514(a) (1973), reprinted at 3 *Leg. Hist.* 2345. Like the Senate version, this bill contained the saving, but no deemer, clause. See *ibid.* See generally H.R. Rep. No. 533, 93d Cong., 1st Sess. 17 (1973), reprinted at 2 *Leg. Hist.* 2348, 2364.

ERISA took a more complex course in the House, however, because the Ways and Means Committee also produced a bill dealing with pension regulation (which contained no preemption provisions at all). See H.R. 12481, 93d Cong., 2d Sess. (1974), reprinted at 2 *Leg. Hist.* 2394. In an attempt to reconcile their efforts, both House Committees produced new and slightly modified substitute bills. See generally 120 Cong. Rec. 4279 (1974) (remarks of Rep. Perkins), reprinted at 2 *Leg. Hist.* 3368-3369.

The deemer clause first appeared, already in its current form, in the substitute for H.R. 2 that emerged from the Education and Labor Committee, where the clause simply was added to the initial preemption and saving clauses. H.R. 12906, 93d Cong., 2d Sess. § 514(b) (1974), reprinted at 2 *Leg. Hist.* 2761, 2961. The Committee did not publish a formal report to accompany this substitute bill, and neither the preemption provisions in general nor the deemer clause in particular were subjects of contention. The only explanation of the entire package of preemption provisions, offered on the House floor, was the con-

clusory statement that "[a]ll States [sic] laws would be pre-empted except for those covering plans not subject to titles II and III [of ERISA]." Remarks of Rep. Perkins (reprinting material in the nature of a Committee report) (Feb. 25, 1974), 3 *Leg. Hist.* 3305. The House passed the bill in this form. See 3 *Leg. Hist.* 4057-4058.

The Conference Committee engaged in extensive re-drafting. See Chadwick & Foster, *Federal Regulation of Retirement Plans: The Quest for Parity*, 28 Vand. L. Rev. 641, 669 (1975). In particular, the conferees "broadened the general pre-emption provision from one that pre-empted state laws only insofar as they regulated the same areas explicitly regulated by ERISA, to one that pre-empts all state laws unless otherwise saved." *Metropolitan Life*, 471 U.S. at 745 n.23. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 n.19 (1983). As the Court has noted, "[t]he change gave the insurance saving clause a much more significant role, as a provision that saved an entire body of law from the sweeping general pre-emption clause." *Metropolitan Life*, 471 U.S. at 745 n.23. But "[t]here were no comments on the floor of either Chamber specifically concerning the insurance saving clause, and hardly any concerning the exceptions to the pre-emption clause in general." *Ibid.* See *id.* at 745. The deemer clause was not mentioned at all in the floor debates.

Although the conferees included the deemer clause in the final bill, there was no substantial discussion of the provision's meaning. The only explanation of the Conference Committee's deliberations on the point indicates, rather unhelpfully, that "some of the staff believe[d] [the deemer clause] should be adopted and other staff believe[d] it should not be adopted." *Summary of the Differences Between the Senate Version and the House Version of H.R. 2 to Provide for Pension Reform, Part III* 33 (1974), reprinted at 3 *Leg. Hist.* 5249, 5283. The conference report simply echoed the statutory language. H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 383 (1974),



reprinted at 3 *Leg. Hist.* 4277, 4650. See generally *Metropolitan Life*, 471 U.S. at 745 n.23.

2. This legislative history is worth considering, of course, because "as in any pre-emption analysis, 'the purpose of Congress is the ultimate touchstone.'" *Fort Halifax*, 482 U.S. at 8 (citations omitted). And ERISA's history is illuminating in several respects. At the outset, it demonstrates that a central concern of Congress was preservation of state authority to regulate insurance; the only constant in the statutory evolution, from introduction of the earliest ERISA bills to enactment of the final version of the statute, was the presence of the insurance saving clause. At the same time, there is absolutely no evidence that Congress had an intention to bar States altogether from the regulation of self-insured plans—evidence that one would expect to find were ERISA designed generally to exclude the States from an area within their traditional purview. To the contrary, "[d]espite the volumes of testimony collected during years of congressional hearings, not a word can be found on the subject of preemption of state regulation of self-insured plans." Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 Iowa L. Rev. 57, 99 (1976) (footnote omitted). See *id.* at 115-116.

Moreover, it is plain from the evolution of ERISA that Congress could not have drafted the language of the deemer clause with the purpose of preempting all state insurance laws as they apply to self-insured plans. As the court below recognized (Pet. App. A20-A21), the deemer clause was put in its current form at a time when the preemption clause applied only to those state laws that dealt with matters specifically covered by ERISA—that is, reporting and disclosure requirements and fiduciary obligations. The language of the deemer clause thus could have been intended, at most, to preempt only state laws addressing those areas. Cf. *Metropolitan Life*, 471 U.S. at 742 n.17.

3. In fact, it seems evident that the deemer clause was directed at a specific and limited problem. At the time

ERISA was enacted, there was some uncertainty about whether self-insured plans generally were subject to state laws regulating the insurance business. Although such plans were becoming common in the 1960s and early 1970s,<sup>5</sup> state insurance commissioners and attorneys general had yet to reach a consensus on whether self-insurers were insurance companies for purposes of laws regulating licensing, reserves, premium taxes, and similar elements of the insurance business;<sup>6</sup> virtually no judicial authority existed on the point.<sup>7</sup> There was concern at the time, however, that treating self-insured plans as insurance companies under state law would effectively drive them out of existence:

Application of state insurance laws to uninsured plans would make direct payment of benefits pointless and in most cases not feasible. This is because a welfare plan would have to be operated as an insurance company in order to comply with the detailed regulatory requirements of state insurance codes designed with the typical operations of insurance companies in mind. It presumably would be necessary to form a captive insurance company with prescribed capital and surplus, capable of obtaining a certificate of authority from the insurance department of all states in which the plan was 'doing business,' establish premium rates subject to approval by the insurance department, issue policies in the form approved by the insurance department, pay commissions and premium taxes required by the insurance

<sup>5</sup> See, e.g., Comment, *State Regulation of Noninsured Employee Welfare Benefit Plans*, 62 Geo. L.J. 339, 340 (1973).

<sup>6</sup> See Brummond, *supra*, 62 Iowa L. Rev. at 90-91 & nn. 309-313; Duesenberg, *The Legality of Noninsured Employee Benefit Programs*, 5 B.C. Indus. & Com. L. Rev. 231 (1964); Goetz, *Regulation of Uninsured Employee Welfare Plans Under State Insurance Laws*, 1967 Wis. L. Rev. 319, 323-325.

<sup>7</sup> See Goetz, *supra*, 1967 Wis. L. Rev. at 322-325; Comment, *supra*, 62 Geo. L.J. at 344-346. The only decisions even arguably on point were a few scattered holdings that insurance companies were not liable for premium or similar taxes on self-funded plans that they maintained for their own employees. See note 10, *infra*.

law, hold and deposit reserves established by the insurance department, make investments permitted under the law, and comply with all filing and examination requirements of the insurance department. The result would be to reintroduce an insurance company, which the direct payment plan was supposed to dispense with. Thus it can be seen that the real issue is not whether uninsured plans are to be *regulated* under state insurance laws, but whether they are to be *permitted*.

Goetz, *Regulation of Uninsured Employee Welfare Plans Under State Insurance Laws*, 1967 Wis. L. Rev. 319, 320-321 (emphasis in original).

These concerns were given added urgency at the time that ERISA was under consideration by the first judicial decision squarely to address the issue, in which a Missouri court held that an employer's self-insured plan was subject to state licensing requirements. *Missouri v. Monsanto Co.*, Cause No. 259774 (St. Louis Cty. Cir. Ct. Jan. 4, 1973), rev'd, 517 S.W.2d 129 (Mo. 1974). The circuit court holding effectively forced the employer to terminate its plan and purchase insurance from a commercial company. See Comment, *State Regulation of Noninsured Employee Welfare Benefit Plans*, 62 Geo. L.J. 339, 345-346 (1973). The decision was pending on appeal during the period that ERISA was under consideration and the deemer clause was drafted.

Against this background, it appears virtually certain that the deemer clause was added in response to the specific concern that self-insured plans would be driven out of existence if they were treated as commercial insurers—if, in the language of the statute, such a plan was “deemed to be an insurance company or other insurer \* \* \* or to be engaged in the business of insurance.” The clause thus was concerned with state laws directed at the *business* of insurance, such as those concerning the creation, management, and structure of insurers. Not coincidentally, these were the general areas dealt with by the original version of the ERISA preemption clause (in place when the

deemer clause was drafted), which would have superseded state laws bearing on fiduciary standards for plan management, as well as plan reporting and disclosure requirements.<sup>8</sup> In contrast, the deemer clause was not directed at other forms of state insurance regulation, such as those involving the relationship between the insured and his insurer.<sup>9</sup> This explains the difference in terminology between the saving and deemer clauses: the former makes no mention of insurance companies or of “business,” saving “any law of any State which regulates insurance”; the latter provides that an employee benefit plan “shall [not] be deemed to be an insurance company or other insurer \* \* \* or to be engaged in the business of insurance.”<sup>10</sup>

<sup>8</sup> The decision below substantially accords with this analysis. While we would not put the inquiry in terms of “pretext” (see Pet. App. A19-A20) or legislative motive—since States may have substantial, legitimate reasons for treating self-insured plans as insurance companies—the crucial element of the court of appeals’ holding was its conclusion that States could not regulate the fiduciary and disclosure obligations of such plans by the simple expedient of labeling them “insurance companies.”

<sup>9</sup> Differentiating between these two types of regulation is not difficult; the distinction often is drawn in general descriptions of insurance law. See, e.g., *Metropolitan Life*, 471 U.S. at 727-728.

<sup>10</sup> A similar line had been drawn prior to the enactment of ERISA by state court decisions addressing attempts to impose premium and related taxes on insurance companies for self-funded plans that they maintained for their own employees. As the New York Court of Appeals put it in the leading (and, at the time of ERISA’s enactment, most recent) such case, although the agreements between the employer and plan participants were understood to be “‘insurance contracts,’” the program “pursuant to which [the company] grants insurance benefits to its employees, is not the doing of an insurance business” because the plan did not “include an amount attributable to profit or contribution to a surplus.” *Mutual Life Insurance Co. v. New York State Tax Comm’n*, 298 N.E. 2d 632, 634, 635 (N.Y. 1973). See *Danna v. Commissioner of Insurance*, 228 So.2d 708, 712-713 (La. Ct. App. 1969); *Williams v. Massachusetts Mutual Life Insurance Co.*, 427 S.W.2d 845, 848 (Tenn. 1968); *State Tax Comm’n v. John Hancock Mutual Life Insurance Co.*, 170 N.E.2d 711, 715-717 (Mass. 1960).



Indeed, the Missouri Supreme Court eventually drew exactly this line between "insurance" (the subject of the saving clause) and the "business of insurance" (the subject of the deemer clause) when, after ERISA was signed into law, it reversed the trial court decision in *Monsanto* on state law grounds. In holding that a self-insured plan was not subject to a Missouri law requiring companies to be licensed before "transact[ing] in this state any insurance business" (517 S.W.2d at 131 (citation omitted)), the court explained: "The term 'insurance business' is not statutorily defined, but it is not the same as 'insurance' or the word 'business' would be meaningless. We must assume that the legislature intentionally added the word 'business,' and that the phrase is to be used in its usual and ordinary meaning." *Id.* at 132. The court accordingly held that the self-insured plan was not subject to state laws specifically directed at insurance companies because "it is not in the business of attempting to make either a profit or accumulate a surplus from the operation of its [plan]." *Ibid.* Notwithstanding the Solicitor General's argument to the contrary (Br. 18-19), in our view the Department of Labor has accepted this distinction, specifically endorsing the *Monsanto* approach in an opinion issued shortly after the enactment of ERISA. United States Department of Labor, ERISA Opinion Letter No. 75-128, at 1 (June 20, 1975).<sup>11</sup>

4. This reading of the deemer clause is entirely consistent with other elements of the legislative history. As we note above, the deemer clause, which was written

<sup>11</sup> The other Department of Labor opinions cited by the Solicitor General (Br. 19 n.13) also are consistent with our reading. Two involved state laws directed at the insurance business. ERISA Opinion Letter No. 78-3A (Feb. 15, 1978) (law requiring that plan receive a certificate of authority and comply with disclosure requirements); ERISA Opinion Letter No. 79-6A (Jan. 16, 1979) (law requiring that self-insurers join reinsurance association as a condition of doing business, and imposing taxes on premiums and benefits paid). The third involved a state law that regulated employee benefit plans in terms. ERISA Opinion Letter No. 82-006A (Jan. 29, 1982).

while the preemption clause was narrowly directed at state laws regulating fiduciary and disclosure obligations, could not initially have been placed in the statute to preclude state regulation of self-insured plans in other areas. As for the preemption clause itself, it apparently was broadened not generally to protect self-insured plans from state regulation, but "out of a fear that 'state professional associations' would otherwise hinder the development of such employee-benefit programs as 'pre-paid legal service programs.'" *Metropolitan Life*, 471 U.S. at 745 n.23 (citation omitted).<sup>12</sup>

At the same time, the general statements in the legislative history about the breadth of ERISA preemption, relied upon by petitioner (Pet. Br. 23) and the Solicitor General (U.S. Br. 14), are simply beside the point. Read in context, it is plain that in every case those statements were directed at the *preemption clause*; while they refer to the breadth of ERISA preemption, the statements note the "narrow exceptions [to preemption] specifically enumerated" in the statute. 120 Cong. Rec. 29,197 (1974) (remarks of Rep. Dent), reprinted at 3 *Leg. Hist.* 4670.<sup>13</sup> Because this case concededly falls within one of the "specifically enumerated" exceptions, the insurance saving clause, the remarks cited by petitioner on the scope of the preemption clause are irrelevant.<sup>14</sup> Petitioner's argu-

<sup>12</sup> As the Court noted, "[t]here is no suggestion that the preemption provision was broadened out of any concern about state regulation of insurance contracts, beyond a general concern about 'potentially conflicting State laws.'" *Metropolitan Life*, 471 U.S. at 745 n.23, quoting 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits).

<sup>13</sup> See 120 Cong. Rec. 29,933 (1974) (remarks of Sen. Williams) (referring to breadth of preemption "with the narrow exceptions specified in the bill"), reprinted at 3 *Leg. Hist.* 4745-4746; 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits) (referring to breadth of preemption "but for certain exceptions"), reprinted at 3 *Leg. Hist.* 4771.

<sup>14</sup> Indeed, in addressing the scope of the exceptions to the preemption clause, the Court has rejected reliance on the "few passing



ments principally serve to emphasize that there were no congressional comments directed to the deemer clause—comments one would expect to find if the clause had a broadly preemptive effect.

Indeed, in contrast to the boilerplate references to the breadth of the preemption clause cited by petitioner, the one specific indication of how Congress intended the preemption provisions to apply supports our reading. Representative Dent, floor manager for the bill in the House and a member of the Committee that produced the deemer clause, explained that ERISA's preemption provisions "followed to a large extent the same approach as in Public Law 93-222 \* \* \* where the regulation of health maintenance organizations [HMOs] was foreclosed to State authority—section 113(a) [sic]." <sup>15</sup> 120 Cong. Rec. 29,197 (1974) (remarks of Rep. Dent), reprinted at 3 *Leg. Hist.* 4670. The statute to which Representative Dent referred as the model for ERISA preemption—which had been enacted in December 1973, around the time the deemer clause was written—preempted state laws relating to the creation and organization of HMOs; in particular, it superseded state requirements that HMOs satisfy the capitalization and reserve obligations imposed on insurance businesses. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, § 1311(a), 87 Stat. 914, 931 (Dec. 29, 1973).<sup>16</sup> But the statute did not preempt state laws addressing the relationship between HMOs and their

references" to the narrowness of the exceptions. *Metropolitan Life*, 471 U.S. at 746.

<sup>15</sup> Congressman Dent in fact had in mind Section 1311(a).

<sup>16</sup> The statute thus preempted laws requiring medical society approval for the creation of HMOs, requiring that physicians constitute a defined percentage of an HMO's governing body, requiring that all or a percentage of physicians in the locale be permitted to participate in providing services for the HMO, or requiring that the HMO meet the "requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency." 87 Stat. 931.

participants. In our view, that is precisely the line drawn by the deemer clause as well.

5. Perhaps because there is so little that is helpful to their case in the contemporaneous legislative history, petitioner and the Solicitor General rely on post-enactment legislative developments. We also could point to post-enactment history.<sup>17</sup> But extensive consideration of this history simply is not fruitful, since the Court repeatedly has made clear in the ERISA setting that "[t]he views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." *Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948, 956 (1989) (citation omitted). See, e.g., *Mackey*, 486 U.S. at 840.

Petitioner and the Solicitor General place principal reliance (Pet. Br. 12 n.7; U.S. Br. 17 n.11) on a post-enactment Committee report, also mentioned by this Court in *Metropolitan Life*, 471 U.S. at 747 n.25, that was written in 1977 and did not accompany legislation. H.R. Rep. No. 1785, 94th Cong., 2d Sess. (1977). On examination, it is not at all clear that the Committee's statements are inconsistent with our reading of the deemer clause.<sup>18</sup> But

<sup>17</sup> At hearings in 1978, for example, "Senator Lloyd Bentsen, the chief drafter of ERISA in the Senate Finance Committee \* \* \* stated that the Finance Committee did not deal with the question of preempting health insurance." 128 Cong. Rec. 30,354 (1982) (remarks of Rep. Burton, reprinting statement of Sen. Matsunaga).

<sup>18</sup> The Solicitor General notes (Br. 17 n.11) the Committee's statement that "the 'deemed' language was utilized to create an irrebuttable presumption that these [benefit] plans are not insurance, trust companies, etc., for purposes of state regulation." H.R. Rep. No. 1785, 94th Cong., 2d Sess. 47 (1977). This, of course, is precisely our understanding of the deemer clause. The Solicitor General (Br. 17 n.11) and petitioner (Br. 12 n.7) also point (with several misleading ellipses) to the Committee's observation that, "[t]o the extent that such programs fail to meet the definition of an 'employee benefit plan,' state regulation of them is not preempted by section 514, even though such state action is barred with respect to the plans which purchase these 'products.'" H.R. Rep. No. 1785, *supra*, at 48. The "programs" referred to by the Committee were those offered by entrepreneurs who sold insurance coverage

in any event, "it is the function of the courts and not the Legislature, much less a Committee of one House of the Legislature, to say what an enacted statute means." *Pierce v. Underwood*, 108 S.Ct. 2541, 2551 (1988). See *Mackey*, 486 U.S. at 840.

Indeed, the wisdom of this rule is especially manifest here, for the report's authors plainly had an imperfect understanding of the operation of ERISA's preemption provisions. The report thus explains that the exceptions to the preemption clause "are designed to delineate affirmatively the limits of the 'field' preempted by section 514(a), and articulate a second, but distinctly subordinate, policy within the section of preserving state authority *insofar as it does not relate to any plan \* \* \**" H.R. Rep. No. 1785, *supra*, at 47 (emphasis added); see *id.* at 46. As Judge Merritt explained for the Sixth Circuit, however, "[t]hese subsequent legislators (or their staff) did not seem to recognize or consider the fact that the 'savings' clause would not be necessary at all if it only saves state laws that do not 'relate to' ERISA plans. The savings clause would not be necessary to save something that the preemption clause had not reached in the first instance." *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85, 89 (6th Cir. 1987), cert. denied, 108 S.Ct. 1754 (1988). Since the authors of the Committee report failed to grasp the application of

(or "products") to employers and employees at large, while seeking to escape state regulation by claiming to be ERISA plans. The Committee's statement expressed the view that such programs were not plans within the meaning of the statute and therefore were subject to state regulation as insurance companies. The bona fide plans that purchased coverage from these programs, of course, could not be treated as—or "deemed" to be—insurance companies, and therefore could not be subjected to state regulation of the business of insurance. Whether the plans might be subjected to other forms of insurance regulation simply was not addressed by the Committee. (Congress ultimately amended Section 514 to make clear that entrepreneurial programs providing insurance to many employers, often referred to as multiple employer health trusts, were subject to full state regulation. See note 4, *supra*.)

the saving clause, there is no reason to suppose that they had a firm appreciation for the substance of the deemer clause. Cf. *Rebaldo v. Cuomo*, 749 F.2d 133, 137 n.1 (2d Cir. 1984) (another portion of report's preemption discussion "lack[s] even persuasive authority").<sup>19</sup>

### C. Preemption Of All State Insurance Regulation As Applied To Self-Insurers Would Run Counter To The Policies Of ERISA.

Our reading of the deemer clause also is faithful to the fundamental policies that underlie ERISA—policies that petitioner and the Solicitor General entirely disregard. ERISA was enacted to correct abuses in the administration of pension plans, and generally "to safeguard employees from the abuse and mismanagement of funds that had been accumulated to finance various types of employee benefits." *Morash*, 109 S.Ct. at 1671. The statute accordingly imposes substantive requirements on pension plans in the areas of funding, vesting, participation,

<sup>19</sup> The Solicitor General also points (Br. 17 n.11) to a 1983 amendment, enacted in response to a decision of the Ninth Circuit, that exempts portions of a Hawaii mandatory health benefits law from preemption under ERISA. Act of Jan. 14, 1983, Pub. L. No. 97-473, § 301(a), 96 Stat. 2605, 2611, codified at 29 U.S.C. § 1144 (b)(5). The Solicitor General finds this amendment significant because it exempts only a single state law. In explaining the amendment, however, the Senate Committee indicated that "the preemption of 'the Hawaii [statute] by ERISA was inadvertent" (S. Rep. No. 646, 97th Cong., 2d Sess. 18 (1982))—hardly a ringing assertion that ERISA as originally enacted had been designed broadly to preempt state health insurance laws. Not surprisingly, the Court rejected the Solicitor General's essentially identical argument from post-enactment history in *Mackey*, 486 U.S. at 839-840. For its part, the Conference Committee in 1983 seemed to believe that the preemption clause reaches only state laws that address matters within the substantive scope of ERISA, stating that the amendment "continues Federal preemption of State law with respect to matters governed by the reporting and disclosure and the fiduciary responsibility provisions of ERISA, as well as certain of the provisions of the administration and enforcement rules of ERISA." H.R. Conf. Rep. No. 984, 97th Cong., 2d Sess. 18 (1982). If this post-enactment history is relevant at all, it plainly is not inconsistent with the holding below. See generally *Mackey*, 486 U.S. at 839-840.



and plan termination. See 29 U.S.C. §§ 1052-1086, 1301-1461. See generally *Alessi*, 451 U.S. at 510-511 & nn. 5-7; *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 374-375 (1980). But welfare benefit plans are not subject to these requirements (see 29 U.S.C. §§ 1051(1), 1081(1)), or to any other comprehensive federal regulation; while ERISA imposes fiduciary and disclosure requirements on the managers of all plans, it "does not regulate the substantive content of welfare-benefit plans." *Metropolitan Life*, 471 U.S. at 732. See generally *Shaw*, 463 U.S. at 91.

Federal law thus provides no regulation of the substance of welfare plans; the universal preemption that petitioner finds in the deemer clause would sweep away the protections of state insurance and health policy as well. Unless the federal courts stepped in to create a federal common law of insurance—a possibility we discuss below—the result of petitioner's approach accordingly would be "a vast regulatory vacuum." *Brummond*, *supra*, 62 Iowa L. Rev. at 118. See *id.* at 100. That outcome, as the Court has noted in a similar setting, "would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Firestone*, 109 S.Ct. at 956. See *Morash*, 109 S.Ct. at 1675. It is impossible to imagine that Congress intended such consequences from a statute "enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans.'" *Firestone*, 109 S.Ct. at 955, quoting *Shaw*, 463 U.S. at 90.

Petitioner's interpretation of the deemer clause would have other anomalous consequences as well. From the standpoint of plan participants—the people who are the intended beneficiaries of ERISA—it is irrelevant whether a plan is self-insured or fully insured; that is a matter of their employer's accounting convenience. Yet petitioner would distinguish on this wholly irrational basis in determining which participants benefit from the protections of state insurance law.

Indeed, petitioner's approach would create irrational distinctions even within plans. Many self-insured plans enter into so-called "stop loss" agreements with insurance carriers, in which the carriers agree to pay individual claims that exceed a certain amount, or to assume all liability for claims once the plan's aggregate insurance obligations exceed a specified limit. See *Brummond*, *supra*, 62 Iowa L. Rev. at 92. These insurance carriers are of course subject to state insurance laws. See *ibid.* Thus, under petitioner's reading of the deemer clause, all of the State's substantive insurance regulations (such as the anti-subrogation provision at issue here) would become fully applicable to a plan that had entered into a stop loss agreement once the plan's coverage limits had been reached and the insurance carrier assumed liability. Whether state law applied to a particular participant's claim therefore would turn on whether the claim was filed before or after total claims reached the coverage limit. Again, it is impossible to imagine that Congress meant the deemer clause to create such a system.<sup>20</sup> See *Shaw*, 463 U.S. at 107-108.

2. Against all of this, petitioner (Pet. Br. 27-29) and the Solicitor General (U.S. Br. 25-27) offer a single argument from the policy and history of the statute: that self-insured plans would find it inconvenient to comply with varying state laws. But this concern is substantially overstated.

The argument for preemption on grounds of administrative convenience relies in large part on fragments of the floor debate indicating that the preemption clause was aimed at "eliminating the threat of conflicting and inconsistent state and local regulation." 120 Cong. Rec. 29,197 (1974) (remarks of Rep. Dent), reprinted at 3 *Leg. Hist.* 4670. See *id.* at 29,942 (remarks of Sen. Javits), reprinted at 3 *Leg. Hist.* 4770-4771; *id.* at 29,933

<sup>20</sup> Similar interpretive anomalies arise in plans—like petitioner's—that hire insurance companies to administer and process claims. See *Brummond*, *supra*, 62 Iowa L. Rev. at 92.



(remarks of Sen. Williams), reprinted at 3 *Leg. Hist.* 4745-4746. As we explain above, however, the floor debate was largely directed at the preemption clause. This case, in contrast, falls within the insurance saving exception to that clause; and, as the Court has explained, "disuniformities \* \* \* are the inevitable result of the congressional decision to 'save' local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress." *Metropolitan Life*, 471 U.S. at 747.<sup>21</sup>

In any event, petitioner fundamentally misses the point of ERISA. The statute was not enacted to protect plans or employers; it was designed to safeguard employees and their beneficiaries. *Firestone*, 109 S.Ct. at 955; *Shaw*, 463 U.S. at 90. See 29 U.S.C. § 1001(b); *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 214 (1986); *Central States Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 569 (1985).<sup>22</sup>

With this in mind, in an area where Congress did not set out applicable minimum standards, concerns for administrative convenience cannot overcome the far more fundamental interest in the protection of plan participants. After all, "one 'uniform rule'"—the rule contended for by petitioner—"would be simply to defer willy nilly to the provisions of the ERISA plan, an obviously arbitrary result that would allow the plan trustees to decide every issue in their own favor without judicial

<sup>21</sup> Moreover, in the context of a debate over preemption, it seems plain that Congress's principal concern was with state rules that conflicted or were inconsistent with the federal law establishing uniform fiduciary and disclosure requirements.

<sup>22</sup> See, e.g., S. Rep. No. 127, 93d Cong., 1st Sess. 1, 13-14 (1973), reprinted at 1 *Leg. Hist.* 587, 599-600; H.R. Rep. No. 533, 93d Cong., 1st Sess. 1 (1973), reprinted at 2 *Leg. Hist.* 2348; 120 Cong. Rec. 29,192 (1974) (remarks of Rep. Perkins), reprinted at 3 *Leg. Hist.* 4657; *id.* at 29,195, 29,196 (remarks of Rep. Dent), reprinted at 3 *Leg. Hist.* 4665, 4668; *id.* at 29,928 (remarks of Sen. Williams), reprinted at 3 *Leg. Hist.* 4733; *id.* at 29,933, 29,935, 29,943 (remarks of Sen. Javits), reprinted at 3 *Leg. Hist.* 4747, 4751, 4775.

review." *Northern Group*, 833 F.2d at 94. But it is hardly likely that Congress meant to establish that sort of uniform rule by abrogating all protections for welfare plan participants. Indeed, in a number of contexts this Court has rejected the contention that the prospect of increased administrative or litigation costs justifies the preemption of state law under ERISA. See *Firestone*, 109 S.Ct. at 956; *Mackey*, 486 U.S. at 831-832; compare *id.* at 843-844 (Kennedy, J., dissenting).

It is worth adding that petitioner substantially overstates the inconvenience and expense of preserving state laws such as the anti-subrogation provision at issue in this case. As Congress was informed in 1982, when it enacted the exemption for Hawaii's mandatory health insurance law upon which the Solicitor General relies (see note 19, *supra*):

[A]ny employer using an automated payroll would not encounter any difficulty or extraordinary cost in meeting different state health care requirements for the following reasons: First, medical benefits are fairly uniform nationwide. Second, payroll offices using automated systems can easily cope with any variations as they do with existing differences for pay packages for workers in different states \* \* \*. If all 50 states developed varying health insurance programs, \* \* \* experts were fairly confident that a computer program could deal with varying benefit packages.

128 Cong. Rec. 30,354 (1982) (remarks of Rep. Burton, reprinting testimony of Sen. Matsunaga). See *id.* at 30,355 (remarks of Rep. Burton, reprinting testimony of Sen. Matsunaga) (noting the "minimal cost" of coping with variations in state law).

3. Petitioner and the Solicitor General similarly argue that their reading of the deemer clause will forestall litigation about the applicability of particular state laws. But it is their analysis, in our view, that would create both considerable uncertainty in the law and a concomitant increase in litigation.

Petitioner seems to assume that preemption would leave it free of all regulation, federal and state. As the Solicitor General candidly acknowledges, however (U.S. Br. 4 n.2), both Congress and this Court have made it clear that, in areas where state law is preempted, "courts are to develop a 'federal common law of rights and obligations under ERISA-regulated plans.'" *Firestone*, 109 S.Ct. at 954, quoting *Pilot Life*, 481 U.S. at 56. See also *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983); 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits), reprinted at 3 *Leg Hist.* 4771. Given the enormous regulatory vacuum that would follow from preemption here, the federal courts would have no choice but to create a federal common law of insurance to resolve questions about, for example, what rule of subrogation to apply. See U.S. Br. 4 n.2.

Such a system would invite confusion and uncertainty. "Over the years states \* \* \* have developed a substantial and complex body of [insurance] law and statutory principles to resolve questions of priority. \* \* \* This corpus of law embodies principles of restitution and risk allocation that have evolved from acquired state experience and expertise." *Northern Group*, 833 F.2d at 94. If state law is not preempted, affected plans may readily determine their obligations by reference to these rules. But that will be impossible if the controlling principles must be found in an inchoate body of federal common law that is discovered by the courts on a case-by-case basis. Giving the federal courts such extensive law-making powers in an area that is not touched substantively by ERISA would make extensive litigation inevitable.

It also would require federal courts to assume a role for which they are profoundly ill-suited. Insurance law has, of course, traditionally been the province of the States. Federal courts accordingly have no experience in applying or developing its principles. And in an area—such as the one involved here—that is not addressed by ERISA, the federal courts would be forced to develop rules "uninformed by any well-defined independent fed-

eral interest." *Northern Group*, 833 F.2d at 94. This Court, moreover, would be obligated to step in repeatedly to set the contours of the new federal common law of insurance. Such a system, it seems to us, is earnestly to be avoided.

#### **D. This Court's Opinion In *Metropolitan Life* Does Not Mandate Preemption.**

In fact, petitioner and the Solicitor General principally rely not on the statutory language, which they barely mention, or on the legislative history, which they set out only in passing. Instead, their argument in large part is grounded on brief snippets taken from this Court's opinion in *Metropolitan Life*. See Pet. Br. 14-16; U.S. Br. 15-18. In particular, they point to two of the Court's statements: the observation that the saving clause must reach laws regulating insurance contracts because otherwise "it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans" (471 U.S. at 741); and the statement that the Court's analysis "results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." *Id.* at 747 (footnote omitted).

These comments cannot bear the weight that petitioner and the Solicitor General place upon them. Both statements are, in fact, literally consistent with our reading of the deemer clause. Under our approach the deemer clause remains necessary to preempt state laws regulating insurance contracts as those laws apply to the *business* of insurance (such as premium levels, commissions, and so on). See pages 15-16 & n.10, *supra*. And it remains true under our understanding of the deemer clause that laws directed at insurance companies—those relating to reserves, premiums, and so on—will have an indirect impact on insured plans but will be inapplicable to self-insured plans.



Having said that, we recognize that there is some tension between a broad reading of these comments from *Metropolitan Life* and the holding below. But that tension should not be dispositive here, for the statements cited by petitioner and the Solicitor General were not essential to the Court's holding in *Metropolitan Life*. As the Solicitor General elliptically acknowledges (U.S. Br. 16), the issue before the Court in *Metropolitan Life* did not involve the application of the deemer clause to a self-insured plan; instead, it concerned the application of the saving clause to an *insurance company*. Thus, as the Court put it, "[t]he narrow statutory ERISA question presented [in *Metropolitan Life*] is whether [the state law at issue] is a law 'which regulates insurance' within the meaning of" the saving clause. 471 U.S. at 738. Indeed, the State had made no attempt to enforce the state law at issue in *Metropolitan Life* against self-insured plans. *Id.* at 735 n.14.

In these circumstances, the Court should not find the most expansive reading of its statements in *Metropolitan Life* to be controlling now. Indeed, the Court already has declined to give force to the broadest interpretation of language taken from *Metropolitan Life* in a case, like this one, that presented issues "the Court had no occasion to consider in *Metropolitan Life*." *Pilot Life*, 481 U.S. at 57. It would be appropriate for the Court to follow the same course here and consider the question in this case with a fresh eye.

## II. IF STATE LAW IS PREEMPTED, FEDERAL COURTS SHOULD ADOPT THE STATE RULE AS THE FEDERAL RULE OF DECISION.

Finally, it should be emphasized that even if the Court disagrees with our reading of the deemer clause and finds that federal law is controlling here, that is not the end of this case. As we explain above, the courts still would have to formulate the applicable rule of federal common law. While that task properly is left to the lower courts on remand, in our view it would be appropriate

for those courts to adopt state law as the federal rule of decision. We accordingly urge the Court (if it finds preemption in the first instance) not to foreclose that as a possibility on remand.

It is, of course, "possible to 'adopt,' as the operative 'federal' law, differing laws in the different States, depending upon the State where the relevant transaction takes place." *United States v. Yazell*, 382 U.S. 341, 356-357 (1966) (citation omitted). In particular, "when there is little need for a nationally uniform body of law, state law may be incorporated as the federal rule of decision." *United States v. Kimbell Foods, Inc.*, 440 U.S. 715, 728 (1979). That may be so even when federal law is made applicable by a statute that preempts the field. See, e.g., *International Union v. Hoosier Cardinal Corp.*, 383 U.S. 696, 701-703 (1966).

Certainly, uniformity is essential in areas where ERISA sets a discernible federal policy. But there is no federal interest in any particular rule governing the subrogation rights of welfare benefit plans, and thus no interest derived from ERISA's policies that mandates application of a uniform national rule. Cf. *Northern Group*, 833 F.2d at 94. The only argument for uniformity offered by petitioner is its contention that it would be burdensome for plan managers to learn the insurance laws of the various States in which they operate. We note that this interest, even if substantial, gives the court no guidance in choosing which uniform rule to apply. But in any event, administrative convenience is not an adequate reason to set aside an entire body of state law: "[t]hrough a uniform [rule] might well constitute a desirable statutory addition, there is no justification for the drastic sort of judicial legislation" sought by petitioner. *Hoosier Cardinal Corp.*, 383 U.S. at 702-703. See *Yazell*, 382 U.S. at 353; *United States v. Brosnan*, 363 U.S. 237, 241-242 (1960).<sup>23</sup>

<sup>23</sup> It should be added that the rule of complete subrogation contended for by petitioner is not desirable as a matter of policy. At a



## CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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minimum, as the Solicitor General notes (Br. 4 n.2), petitioner should not be permitted to obtain full reimbursement out of respondent's tort settlement if respondent has not been made whole for her medical expenses, a point on which the record is silent. See U.S. Br. 3 n.1. But beyond that, respondent's tort suit included claims both for medical expenses and for pain and suffering; given the extent of her injuries, the latter claim surely was substantial. Some (if not all) of the tort settlement, which amounted to only a fraction of respondent's claim, therefore plainly reflected recovery for pain and suffering. Allowing the insurer to obtain this recovery to cover its outlays for medical expenses "would require diversion of the insured's recovery for \* \* \* pain and suffering and [would] completely deplete the insured's recovery for damages. It would also allow the insurer to recover 100% of its expenditure while the insured only recovered [a fraction] of [her] damages." *Allstate Insurance Co. v. Clarke*, 527 A.2d 1021, 1025 n.5 (Pa. Super. Ct. 1987). In such circumstances, "[t]here would be nothing equitable in awarding the entire [settlement] to the medical insurer." *Ibid*. If sound policy and equity are to underlie a controlling common law rule, on remand the courts below should be free to reject petitioner's approach.